DEPT.- 65

JOB- 21

REEL- 50

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

PP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

XP 23607

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Blks.

D 81675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 D 81675

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Mrs Fred~~ Argenta F. Schneider

(a) RESIDENCE NO. Hilton Court Apt. B.14 Liberty Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Fred Schneider (deceased)

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Maloney (D)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Maria Duncan (D)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs M. L. Banner

(Address) Hilton Ct. Liberty Heights Ave.

15 Filed DEC 12 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1923, to Dec 11, 1923, that I last saw her alive on Dec 11, 1923, and that death occurred, on the date stated above, at 8:20 P.m.

The CAUSE OF DEATH* was as follows:

Appendicitis, (ruptured) Localized

Appendix abcess, Later developed

Bronchial Pneumonia

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Hilton Court Apts, Liberty Heights Ave.

Did an operation precede death? yes Date of Nov. 27, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation, + X ray of chest.

(Signed) Raymond L. Johnston, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	12/14/23
20 UNDERTAKER	ADDRESS
W. J. Sykes & Son	Walbrook

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81676

CERTIFICATE OF DEATH.

90 D 81676

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 S. Harris ST., 1 WARD)

2-FULL NAME Mary Gerhardt.

(a) RESIDENCE NO. 928 S. Harris ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph E Gerhardt.

6 DATE OF BIRTH (month, day, and year) Aug. 29th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Kubucki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm A. Eyring

(Address) 928 S. Harris St

15 DEC 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov ..., 1923, to Dec 10 ..., 1923.

that I last saw h.r alive on Dec - 9 ..., 1923,

and that death occurred, on the date stated above, at 2 50 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis &
Mitral Insufficiency

(duration) Several yrs. ... mos ... da.

CONTRIBUTORY (Secondary) Chronic Gastritis

(duration) ... yrs. 1 mos. ... da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) M. J Brandon, M. D.

. 19 (Address) 2035 Edmondson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec. 12th 1923
20 UNDERTAKER Lilly - Zeiler	ADDRESS 4033 W. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81677

CERTIFICATE OF DEATH.

74-001

74 D 81677

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 Bond ST., 3 WARD)

2-FULL NAME Ignatius Ladna.

(a) RESIDENCE No. 833 S. Bond. ST., 3 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary Ladna.

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore 074

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant Anna Young.

(Address) Care Dr. Ladd

15 Filed DEC 12 1923 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11th 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/8, 1923, to 12/11, 1923, that I last saw h~~e~~ alive on 12/10, 1923, and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Ureteral calculus & chronic diffuse nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) H. A. Bullock, M. D.

12/14 1923 (Address) 162 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Dec. 13 1923
20 UNDERTAKER Lilly & Feiler	ADDRESS 1043 S. Mosher

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cir.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81678

CERTIFICATE OF DEATH.

113 D 81678

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 237 So. Bond ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Boguslawski

(a) RESIDENCE NO. 237 So Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	—	—	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Stanislaw Boguslawski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER V. Boguslawski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant V. Boguslawski
(Address) 237 So Bond St

15 Date received DEC 12 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions (duration) ..... yrs. ..... mos. 1 hr.

CONTRIBUTORY (Secondary) Intestinal Indigestion (duration) ..... yrs. ..... mos. 3 ds.

(Signed) Thos. B. Horton, M. D. (Coroner.)

(Address) Curtis Bay Dec 12 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	12/12 1923
20 UNDERTAKER	ADDRESS
Wm Fiaskowski	1618 Eastern

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81679

CERTIFICATE OF DEATH.

D 81679

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Ackenrode

(a) Residence No. Preston & Valley Sts. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 16 Jan. 1846

7-AGE. 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Taneytown, Md.

PARENTS.

10-NAME OF FATHER. Samuel Ackenrode

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Althoff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Sister Florence

(Address) Preston & Valley Sts

15- DEC 12 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/12/23

17- I HEREBY CERTIFY, That I attended deceased from 12/5 1923 to 12/12 1923 that I last saw her alive on 12/10 1923 and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. H. Lemon M. D

1923 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Emmitsburg 2nd — DATE OF BURIAL. 12/12 1923

20-UNDERTAKER. Chas. G. Black — ADDRESS 1422 N. Northern

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-001

D 81680

CERTIFICATE OF DEATH.

D 81680

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Boran
S.

(a) RESIDENCE No. 1313 Pratt St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ignatz Boran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bani Chemor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 12 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from December 3, 19 23, to December 9, 19 23, that I last saw him alive on December 9, 1923, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G Grace, M. D.

12-10-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cem	12/12/1923
20 UNDERTAKER	ADDRESS
D J Fahey & Sons	1318 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholism

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

15-9-89 Md 81681

CERTIFICATE OF DEATH. X 90 D 81681

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ... St., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Waters

(a) RESIDENCE NO. 21 Thames St., WARD Cincinnatti Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 years ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Jessie Waters

6 DATE OF BIRTH (month, day, and year) Sept 1-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired - Office Manager

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Catherine Mennery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 DEC 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1923, to Dec 11, 1923, that I last saw him alive on Dec 11, 1923, and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? C M

(Signed) Trevor Owen, M. D.

Dec 12th 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Watseka Ill via Sheldon Ill. DATE OF BURIAL Dec 12 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W NORTH AVE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81682

CERTIFICATE OF DEATH.

74-002

D 81682

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 211-W-Madison ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hall Richardson

(a) RESIDENCE NO. 211-W-Madison ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 65 yrs. 2 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Stanbery L Richardson

6 DATE OF BIRTH (month, day, and year) Oct 4 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Somerset Co. (State or country) Md

PARENTS

10 NAME OF FATHER Edwin Long

11 BIRTHPLACE OF FATHER (city or town) Somerset Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Hawker

13 BIRTHPLACE OF MOTHER (city or town) Ritland (State or country) Vermont

14 Informant Mrs Ruth Lyle (daughter)

(Address) 211 W Preston St.

15 Filed DEC 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1923, to Dec. 11, 1923, that I last saw her alive on Dec 11, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Embolus in a cerebral vessel-
hemiplegia rt. side of body-
Embolus - pulmonary vessel right
base - cardiac dilatation (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis - auricular fibrillation (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination.

(Signed) Harry L. McCarty, M. D.

12-12-1923 (Address) 37 W. Preston Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington - D.C.

DATE OF BURIAL Dec 13 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE

THIS STATEMENT MUST BE CAREFULLY PREPARED. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 Dp 43 81683

CERTIFICATE OF DEATH. X 90 D 81683

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.** REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Friend

(a) RESIDENCE NO. West Seaford Del ST., WARD Seaford Del

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Susie Friend

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer G.P.O.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portugal

PARENTS

10 NAME OF FATHER Natalis Friend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portugal

12 MAIDEN NAME OF MOTHER Geneva Feranis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portugal

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

DEC 21 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1923, to Dec 10, 1923, that I last saw him alive on Dec 10, 1923, and that death occurred, on the date stated above, at 10 20 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Aortic insufficiency

(duration) yrs. Not known mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. P. Harrison, M. D.

12/20/23 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Seaford Del	Dec 12 1923
20 UNDERTAKER	ADDRESS
J. R. Brown & Son	Seaford Del

Burial Permit Clerk Edrema PRR

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81684

CERTIFICATE OF DEATH.

X 49

D 81684

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Burrier

(a) RESIDENCE NO. Belair, Md. R. 7 Sta #2 WARD Bel Air Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Lorena Burrier

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John A. Burrier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ....., 19 Robert P. Harrison, Registrar

DEC 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1923, to Dec 12, 1923, that I last saw him alive on Dec 12, 1923, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - Glioma

Malignant

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harford Co Md

Did an operation precede death? Yes Date of June 10-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam

(Signed) Warfield M Finan, M. D.

12/12, 1923 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bel Air Md	Dec 14 1923
20 UNDERTAKER	ADDRESS
Jos T Foster	Bel Air Md

matlon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81685

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-00 D 81685

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. " ST., 76 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annette Winkler

(a) RESIDENCE NO. Eastern Ave Rd + ST., Baltimore WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 24-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore - Md.
(State or country)

PARENTS

10 NAME OF FATHER Winkler. Oscar S.

11 BIRTHPLACE OF FATHER (city or town) Balto - Md
(State or country)

12 MAIDEN NAME OF MOTHER Gerhandt

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant- Records - John Hopkins Hosp.
(Address)

15 Filed ..... 19 .....
Registrar

DEC 12 1923

[Robert P. Harrison, Deputy Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1923, to Dec 11, 1923, that I last saw her alive on Dec. 11, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism - (Exophthalmic Goitre) -

(duration) yrs. 11 mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. 8 mos. ..... ds.

18 Where was disease contracted if not at place of death? - Balto

Did an operation precede death? Yes Date of Dec 10

Was there an autopsy? -

What test confirmed diagnosis? - Exam. of tissue removed at operation.

(Signed) Fred H. Allen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Dec 4 19 23
20 UNDERTAKER Sorkin & Sorkin	ADDRESS 1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Lenery)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81686

CERTIFICATE OF DEATH.

12 ✓ D 81686

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. South Baltimore Gen'l Hosp ST., 24 WARD)

2-FULL NAME Pauline Lenery

(a) RESIDENCE NO. 1138 Cookes ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Lenery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Hanakovic

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Croatia

14 Informant (Address) Peter Lenery 1138 Cookes st

15 Robert F. Harrison. ....., 19.....

C 127923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 3, 1923, to December 11, 1923, that I last saw her alive on December 11, 1923, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) John A. O'Connor, M. D.

19 (Address) 1704 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 12/13 1923

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1159 Eager

WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can he known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should he used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

No other history

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81687 HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 D 81687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 309 S. Bouldin ST.) (76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Steinkrauss

(a) RESIDENCE. No. 309 S. Bouldin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of) (or WIFE of): Late Henry Steinkrauss

6 DATE OF BIRTH (month, day, and year): 12. 10. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeper

(c) Name of employer: God

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Steinkrauss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catharine Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Mary Priebe 309 S. Bouldin St.

15 DEC 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12. 11. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1923 to Dec 10 1923, that I last saw h[illegible] alive on Dec. 10 1923, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows: Infirmities of Old Age. Chronic Bronchitis

CONTRIBUTORY (Secondary): Hypostat. Pneumonia (duration) yrs. mos. 10 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What tests confirmed diagnosis? —

(Signed) Wm. A. Meyer M. D.

11. 1923 (Address) 1031 N. Carolina Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cemetery	Dec 13 1923
20 UNDERTAKER	ADDRESS
Louis Heeman	32 S Broadway

DEC 12 1923

Mail

Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81688

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 ✓ D 81688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. N.W.Cor. Eutaw & Hoffman Sts. ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Mc Nichol

(a) RESIDENCE No. N.W.Cor. Eutaw & Hoffman Sts. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1858 guess

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65 yrs.	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) school teacher
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Bernard Mc Nichol

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Maria Crane

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Estelle V. Devereaux
(Address) 537 E. Northern

15 Filed ....., 192 Robert F. Harrison, Registrar

C 121923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

asphyxia Illuminating gas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (accidental)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Dec. 11, 1923 (Address) 2-902 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 12/13 1923

20 UNDERTAKER Chas. F. Evans & Son — ADDRESS 11 W. Saratoga Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SAFE

Spec.—1-10-21—M&T—1500 Bks.

D 81689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81689

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2553 Florence St (ST.) 13 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Butler

(a) RESIDENCE NO. 2553 Florence ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eugene Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Clifton T. Butler 2553 Florence St.

15 Filed ..... 19 ..... Registrar

C 21923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1923 to December 10 1923.

that I last saw her alive on December 9, 1923.

and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Disease Leakage of Heart + Bright

(duration) yrs. 4 mos. 5 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. L. W. Kennard M. D.

12-10 1923 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Dec 13 1923
20 UNDERTAKER	ADDRESS
Brown + Fleeland	Lafayette

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

DEATH

Spec.—1-10-21—M&T—1500 Bks.

D 81690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Reed

(a) RESIDENCE No. 605 Sarah Ann st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Custis Jaws

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Willie Pollum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed DEC 12 1923, 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1923, to Dec. 9, 1923, that I last saw her alive on Dec. 9, 1923, and that death occurred, on the date stated above, at 11.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

12-10-23 (Address) Municipal Tbc Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Dec 13 1923
20 UNDERTAKER	ADDRESS 114 W
Brown & Frankland Schuda	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 81691 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81691

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1 Registered No.....

City of BALTIMORE: (No. 2425 Fait Ave St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard J. Ziolkowski

(a) Residence No. 2425 Fait ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 17 1923

7-AGE		If LESS than 1 day
yrs.	mos. 25 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Mathew . Ziolkowski

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Minney. Bortman

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Mathew . Ziolkowski

(Address) 2425 Fait ave

15- Filed DEC 12 1923, 192 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12 '23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11 1923 to Dec 12 1923

that I last saw ... alive on ... 12 1923

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

3
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

12/17/23 (Signed) C. O. Beer M. D.

(Address) 408 E Pat Pk Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Swartz	Dec. 13 19 23
20-UNDERTAKER,	ADDRESS
John H. Weber	1803 Bank

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 81692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81692

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH:

City of BALTIMORE: (No. 211 Ivy Alley St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hom Doe

(a) Residence No. 211 Ivy Alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Hom Wong Shee

6-DATE OF BIRTH (month, day and year) 1860

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), China

PARENTS.

10-NAME OF FATHER, Hom Lom

11-BIRTHPLACE OF FATHER (city or town) (State or Country). China

12-MAIDEN NAME OF MOTHER, Chin Shee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). China

14- (Informant) Hom Lim

(Address) 18 E. Fayette St.

15- Filed Dec 12 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 11/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1923 to Dec 11/23 19.....

that I last saw him alive on Dec 11/23 19..... 1220 M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Hemiplegia, Apoplexy

Left Side

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) High Blood Pressure Cardiosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Holt M. D

Dec 12 23 (Address) 103 Light

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Dec 14 1923

UNDERTAKER. John O. Mitchell ADDRESS 120 W Fayette

DEC 12 1923

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 81693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 N. Carrolton ave ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME R. Matilda Graham.

(a) RESIDENCE No. 323 N. Carrolton ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Robt. C. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Jane Ross.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Thomas R. Graham.

(Address) 323 N. Carrolton ave.

15 Filed DEC 12 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2nd, 1923, to Dec-11, 1923, that I last saw he alive on Dec-11th, 1923, and that death occurred, on the date stated above, at 2-00 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. Mac Jones, M. D.

, 19 (Address) 7802 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12/13 1923
20 UNDERTAKER	ADDRESS
Thos. G. Black.	742 W. North Ave

THIS CERTIFICATE SHOULD BE CAREFULLY PREPARED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates. OCCUPATION

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81694 ✓ D 81694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Southern Hospital. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2520 Fremont Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Alice Roles

(Residence in Baltimore: No Annapolis Md. St.; ....yrs., 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Dec. 1, 1847 (Month) (Day) (Year)

7-AGE, 76 yrs. ..... mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

9-BIRTHPLACE, (State or Country), Bath - Somerset Co. England.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Dr. F. Serl Frederick.

(Address) Annapolis Md.

15- Dec. 12, 1923 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1923
December (Month) 12 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1923, to Dec. 12 1923, that I saw h.. alive on Dec. 12 1923, and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast

(Duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Metastases to lungs.

(Duration) 4 yrs. 6 mos. 3 ds.

(Signed) Dudley P. Bowe M. D.

Dec. 12, 1923 (Address) 104 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 2 mos. 6 ds. In the State 50 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Annapolis Md.

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md. DATE OF BURIAL, Dec 15, 1923

20-UNDERTAKER Jas. L. Taylor Sons ADDRESS Annapolis, ~~Md~~

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81695

CERTIFICATE OF DEATH.

129 D 81695

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Cedarcroft Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marjorie Carey

(Residence in Baltimore: No. 417 Cedarcroft Road St.; 2 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 26, 1879 (Month) (Day) (Year)

7-AGE, 43 yrs. 11 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wallace Thompson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Julia Green

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida B Thompson

(Address) Remington Va

Filed DEC 13 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 11, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 11 1923, to Dec. 11 1923, that I saw h[illegible] alive on Dec 11 1923, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Acute Substantial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Interstitial Nephritis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Wm J Pellsbury M. D.

Dec 11, 1923 (Address) 416 Cedarcroft Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In this State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Remington Va — DATE OF BURIAL, 12/13/1923

UNDERTAKER, Samuel J. Hensley — ADDRESS 1 Baldwin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks I turned to Chronic

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81696

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 81696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 751 Sarah Ave St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Fisher

(a) Residence No. 751 Sarah Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Rosa Fisher

6-DATE OF BIRTH (month, day and year): Aug 25-1864

7-AGE: 54 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 840
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Frederick Md

PARENTS.

10-NAME OF FATHER: Isaac Fisher

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Hannah Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-(Informant): Rosa Fisher
(Address): 643 George St

15-Filed DEC 13 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 10/1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 17 1923 to Dec 10 1923

that I last saw h.. alive on Dec 10 1923

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Chr. Int. Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas P Dorsey M. D

Dec 11, 1923 (Address) 1502 McCulloh St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 12/13, 1923
Mt Lebanon Cem.	
20-UNDERTAKER: Edward J Stanley	ADDRESS: 1728 Edmondson Ave

Instructions to Physicians and Undertakers. Blanks should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 81697

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Aisquith ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel J. Eppler

(a) RESIDENCE NO. 1200 Aisquith ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Florence T. Eppler

6 DATE OF BIRTH (month, day, and year) Bal Co

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mr. Eppler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Florence T. Eppler

(Address) 1200 Aisquith St

15 Filed DEC 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/12 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/12, 1923, to 12/12, 1923, that I last saw h— alive on 12/12, 1923, and that death occurred, on the date stated above, at 10 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 1/2 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Bernard Ross, M. D.

12/12, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Harford Road — DATE OF BURIAL Dec. 15 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 81698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2302 Mcculloh St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Klein

(a) Residence No. 2302 Mcculloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rose Klein

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 58 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St

DEC 13 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-13-23

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Dec 11th, 1923, that I last saw h. alive on Dec 11, 1923, and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Michael A. Abrams, M. D.

Dec 13, 1923 (Address) 2360 Eutaw place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Friendship Cem

DATE OF BURIAL, 12/16 1923

20-UNDERTAKER, Jack Lewis

ADDRESS 1439 E. Baltimore St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81699

CERTIFICATE OF DEATH.

66 D 81699

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 103 N. Tenth ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Mohr

(a) RESIDENCE NO. 103 N. Tenth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Mohr

6 DATE OF BIRTH (month, day, and year) Aug 25/1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 640
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jacob Mohr

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Henry L. Mohr
(Address) 103 N. Tenth St.

15 DEC 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Harry L. Horton, M. D.
(Coroner)

Dec 12 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cemetery Crem	Dec 15 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81700

CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO. D 81700

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Gough ST., 3 WARD)

2-FULL NAME Sarah D. Davis

(a) RESIDENCE No. 1502 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Davis

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert County Md.

PARENTS

10 NAME OF FATHER: James Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert County

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert County

14 Informant: Samuel Davis

(Address) 1504 Gough St

15 DEC 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1923 to Dec. 10, 1923, that I last saw h[illegible] alive on Dec. 9, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) yrs. mos. , da.

CONTRIBUTORY (Secondary): Cardiac asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Robinson M. D.

12/13/23 (Address) 1320 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetary	Dec 13 1923
20 UNDERTAKER	ADDRESS
Jos. J. H. Rochester	1413 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--1-12-23--MAT--100 Blks.

D 81701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 81701

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Quarantine Hospital ST., WARD)

2-FULL NAME Edward W Nash (Nash)

(a) RESIDENCE NO Hotel Belvedere ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: 69 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mt Pleasant
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Chas. Wells Hotel Belvedere
(Address)

15 DEC 13 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 1923 ~~Dec 13~~ U.T.D.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bad disease heart

Duration unknown

CONTRIBUTORY (Secondary) Syphilis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

(Signed) W. J. Gilly M. D.
Dec 13. 1923 (Address) (Coroner.) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) In the City
At place of death yrs., mos., ds. State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Dec. 17 1923

20 UNDERTAKER: Martin WE Dipple. ADDRESS: 373 Saratoga St

IMPORTANT: Before the certificate is filled out the undertaker should call at the office of the Registrar of Vital Statistics, 100 Holliday Street, to learn whether it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86-001

D 81702

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1843 W Balto. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agusta Irma Hauff.

(a) RESIDENCE. NO. 1843 W Balto. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): S.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-17-1909

7 AGE — Years: 14 — Months: 7 — Days: 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Hauff. M.D.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Elizabeth M. Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: John Hauff. M.D.
(Address): 1843 W Balto Md.

15 Filed DEC 13 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-11- , 1923, to 12-12, 1923 that I last saw h[illegible] alive on 12-12, 1923 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Otitis Media.
Lateral sinus thrombosis

(duration) 3 yrs. mos.

CONTRIBUTORY (Secondary) Pulmonary Infarction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) J. Demarco, M. D.

12-12 1923 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec. 15 1923

20 UNDERTAKER: George L. Schnorbus — ADDRESS: 1101 Fredk Ave.

-mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 81703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81703

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 McDonough St ST.; 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Russell Beach

(a) RESIDENCE. NO. 1037 McDonough St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

GE should be stated EXACTLY. PHYSICIANS should state
hat it may be properly classified. Exact statement of OCCUPA-
ns on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 9, 1902

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Coal etc.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George H. Beach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Cora Minnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Raymond Beach
(Address) 1037 McDonough St

15 DEC 13 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from December 9, 1923, to December 11, 1923, that I last saw him alive on December 11, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal Lues

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis J. Ayd, M. D.

Dec 12, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec. 13 1923
20 UNDERTAKER	ADDRESS
Wm Corkran	502 E. Fayette Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81704

CERTIFICATE OF DEATH.

74-001

74 D 81704

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward McGrail (McGrail)

(a) RESIDENCE NO. 3518 Myrtle Place ST. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett McGrail.

6 DATE OF BIRTH (month, day, and year) 1886 Jan.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
~~37~~	37	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 86

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffer

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas McGrail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Meeks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records.
(Address)

DEC 13 1923 ROBERT H. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/3/23, 19..., to 12/11/23, 19..., that I last saw him alive on 12/11/23, 19..., and that death occurred, on the date stated above, at 2.25 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical - Autopsy

(Signed) K. W. Dolley, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Dec 14 1923

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

THIS DEPARTMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81705

CERTIFICATE OF DEATH.

74-001

D 81705

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Wordlea Ave. ST., Gardenville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilie Naegele

(a) RESIDENCE NO. 11 Wordlea Ave. ST., Gardenville WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Naegele

6 DATE OF BIRTH (month, day, and year) Oct 11 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hemingsen Germany

PARENTS

10 NAME OF FATHER Bernard Krieger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Sommerkamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John A. Naegele Gardenville Md.

15 DEC 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1923, to Dec 12, 1923, that I last saw h alive on Dec. 11, 1923, and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,
Left Hemiplegia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sunland Fritz, M. D.

12, 1923 (Address) Arcadia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 14 1923
20 UNDERTAKER	ADDRESS
Fred'k Lee & Son	Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81706

CERTIFICATE OF DEATH

114 D 81706

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 Furley Ave. ST., Gardenville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Leonard Ravadge

(a) RESIDENCE NO. 326 Furley Ave. ST., Gardenville WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1st 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Ravadge

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Lehnert

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Annie Ravadge (Address) 326 Furley Ave Gardenville

15 DEC 13 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1923, to Dec 11th 1923, that I last saw him alive on Dec 11th, 1923, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions of gastric origin

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edw H Benson, M. D.

(Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 14 23
20 UNDERTAKER	ADDRESS
Fredk Lessenden Sons	Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81707

CERTIFICATE OF DEATH.

89 D 81707

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Federal St. ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harrison Wilson

(a) RESIDENCE No. 1708 Federal St. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude E. Wilson

6 DATE OF BIRTH (month, day, and year) Audist 1/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	4	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) Dental Supplies
(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Upton Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Gertrude E. Wilson
(Address) 170[illegible] Federal St

15 Filed DEC 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Weller, M. D.
(Coroner.)

Dec 12/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 13 1923
20 UNDERTAKER	ADDRESS
W. M. Routson	2238 N. [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks. MARY YÜTTNER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81708

CERTIFICATE OF DEATH.

1294 D 81708

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Manchester Apt D-14 St., WARD)

2-FULL NAME Mary Yüttner

(a) RESIDENCE NO. Madison Ave & Bloomdt St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2nd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bruce & Simon Funeral Dirs

(Address)

15 Filed DEC 13 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Dec 11, 1923, that I last saw h.. alive on Dec 11, 1923, and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia (Chronic nephritis)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis; Arteriosclerosis Symptoms yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jno P Staubinger, M. D.

Dec 12, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL Dec. 14th 1923

20 UNDERTAKER H. David Goodheim — ADDRESS 118 Whitelock St

MAIL THIS PAPER TO REGISTRAR OF RECORDS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81709 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 81709

X 118-007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1806 E. Madison ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angeline Williams

(a) RESIDENCE NO. 1806 E Madison ST., WARD Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Williams

6 DATE OF BIRTH (month, day, and year): Mar 10 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	–	–	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State of country): Va.

PARENTS

10 NAME OF FATHER: Chas. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Pattie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Mary L. Branch. 1806 E. Madison St.

15 DEC 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1923, to Dec. 11, 1923, that I last saw h[illegible] alive on Dec. 10, 1923, and that death occurred, on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal Volvulus

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary): Indigestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Halifax County Va.	Dec 13 1923
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1225 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81710

CERTIFICATE OF DEATH.

148 D 81710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., No WARD)

2-FULL NAME Elizabeth Hawkins

(a) RESIDENCE No. 3205 O'Donnell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Hawkins

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 05

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Herman Andree

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Alma Esse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Patrick Hawkins

(Address) 3205 O'Donnell St.

15 DEC 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from 12 - 10, 1923, to 12 - 11, 1923, that I last saw h[illegible] alive on 12 - 11, 1923, and that death occurred, on the date stated above, at 11 40 a m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs 8½ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12-11-23.

Was there an autopsy? Yes

What test confirmed diagnosis? P.S.S.

(Signed) Harold C. Pillsbury, M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 15 1923
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1110 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81711

CERTIFICATE OF DEATH.

47 D 81711

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Gorsuch ave ST. 9 WARD)

2-FULL NAME Regina Homfeldt

(a) RESIDENCE No. 1523 Gorsuch ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, ~~(write the word)~~: Widowed

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Henry G. Homfeldt

6 DATE OF BIRTH (month, day, and year): March 14 1861

7 AGE: Years 62 yeas; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Hamand Shufeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Infang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elizabeth Homfeldt

(Address) 1523 Gorsuch Ave

15 Filed DEC 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 10, 1923, that I last saw h[illegible] alive on Dec 10, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Toxaemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bowel & Breast with cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of ?

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

12/13, 1923 (Address) 706 Maynard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 13 1923

20 UNDERTAKER: Robt J Turner Jr — ADDRESS: 1402 N Broadway

THIS DEPARTMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81712 — 45 D 81712

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 8 WARD)

2-FULL NAME Lead of Fiddler

(a) RESIDENCE NO. 2415 E. Chase ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Chas Rosing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas. A Fisher
(Address) 2415 E Chase St

15 DEC 13 1923 ROBERT R. KRAUTER Registrar
Bureau of Vital Statistics Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-21, 1923, to 12-13, 1923, that I last saw h.e alive on 12-13, 1923, and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Metastatic Intramedullary Sarcoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Vesico Fistula

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 27

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) J. Hamilton Wilson M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 15 1923
20 UNDERTAKER	ADDRESS
Robt. T. Turner Inc	1404 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81713 ✓ D 81713

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 2557

City of BALTIMORE: (No. 2468 Washington Blvd. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Alexander Jones

(a) Residence No. 2468 Washington Blvd. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian M. Jones

6-DATE OF BIRTH (month, day and year) Nov. 7, 1852

7-AGE	If LESS than 1 day,
71 yrs. 1 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Supt. Mutual

(b) General nature of industry, business, or establishment in which employed (or employer): Life Insurance

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: Joseph A. Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Christine Alshlager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14-

(Informant): Mrs. Lillian M. Jones

(Address): 2468 Washington Blvd.

15-

Filed ..... 19.....

16-ROBERT R. KRAUTER, Registrar.

DEC 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from 1921, 19....., to Dec 12, 1923,

that I last saw ~~him~~ alive on Dec 12, 1923,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Uremic Coma

(Duration) no yrs. no mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Uremia

(Signed) Raymond Glenn, M. D.

12-12 1923 (Address) Lakeland, Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Loudon Park Cem	Dec 15, 23
20-UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.&R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81714

D 81714

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 36 S. Poppleton St. St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Minnie Sonnenburg

(a) Residence No. 36 S. Poppleton St. St., Ward.....
(Usual place of abode). (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Sonnenburg

6-DATE OF BIRTH (month, day and year): 1846

7-AGE: 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment, in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: Peter Kratzenstein

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Fisher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Richard Sonnenburg

(Address): 36 S. Poppleton St.

15-

Filed DEC 13 1923 19..

RUBERT K. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 11, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1923 to Dec 11 1923

that I last saw h[illegible] alive on Dec 10 1923

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Obstruction

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Campbell, M. D.

Dec 12 1923 (Address) 1644 S. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Park Cem

DATE OF BURIAL: Dec 13 1923

20-UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Eutaw

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81715

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 11 S. 3rd ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Bosson

(a) RESIDENCE No. 11 S 3rd ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Marie Bosson

6 DATE OF BIRTH (month, day, and year): July 26. 1872

7 AGE — Years: 51 — Months: 4 — Days: 14 — If LESS than 1 day.... hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of Industry, business, or establishment in which employed (or employer): Casket maker

(c) Name of employer: Nat. Casket. Co. 014

9 BIRTHPLACE (city or town) (State or country): Homestead Md

PARENTS

10 NAME OF FATHER: George Bosson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt. County.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt. County.

14 Informant: Mrs. Anna M. Bosson

(Address) 11. S. Third st.

15 Filed DEC 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923, to Dec 10, 1923

that I last saw him alive on Dec 10, 1923,

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

a Arteriosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tickner M. D.

12/11, 1923 Address 315 S Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hempstead Cemtery.

DATE OF BURIAL: Dec. 1923

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—E. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81716

CERTIFICATE OF DEATH.

3 / D 81716

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Gough ST.: 2 WARD)

2-FULL NAME Mary Grzeczka

(a) RESIDENCE. NO. 1727 Gough ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. - mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Michael Grzeczka

6 DATE OF BIRTH (month, day, and year): May 12

7 AGE: 63 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Nowanshi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Agnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Hellen Grzeczka
(Address) 1727 Gough St

15 Filed DEC 13 1923 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25 1923 to Dec 11 1923

that I last saw h- alive on Dec 10 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 9 mos.
(duration)

CONTRIBUTORY (Secondary) Myocardial insuffa 9 mos.
(duration)

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Leo. Keller M. D.

12-13-23 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross German Hill Road	December 1923
20 UNDERTAKER	ADDRESS
Wendell Riffel & Son	378 Mnn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

(Meiser) ok Keyser ✓

D 81717

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 81717

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 907 North Monroe St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Meiser

(a) Residence No. 907 North Monroe St., ... Ward.....
(Usual place of abode)

Length of residence in city or town, where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed or divorced, HUSBAND of (or) WIFE of Late Caroline Meiser

6-DATE OF BIRTH (month, day and year) May 7th 1837

7-AGE, 86 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mason

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Andrew Meiser

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Dora Knorr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mrs John H. Crockett

(Address) 907 N. Monroe

15-Filed ..... Robert P. Hartigan, Registrar.

C 131923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12th 1923

17-I HEREBY CERTIFY, That I attended deceased from Dec 6th, 1923 to Dec 12, 1923

that I last saw him alive on Dec 12 1923

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Keyser M. D.

, 19 (Address) Wentworth Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery — DATE OF BURIAL, Dec 14 — 1923

20-UNDERTAKER, Geo. Weber's Son — ADDRESS 503 Edmondson Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81718

CERTIFICATE OF DEATH.

185 D 81718

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Skipwith Murray

(a) RESIDENCE No. Guilford Ave. & 21st St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3rd 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	82	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER William Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Skelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Gay B. Rawlins

(Address) 119 W 22nd St.

15 Filed ..... Robert P. Harrison, Registrar

FC 137923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Dec 12, 1923, that I last saw her alive on Dec 12, 1923, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Fracture of femur (Over)

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Uremia —

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical diagnosis Urinary analysis.

(Signed) Wm Mayo, M. D.

12/13 1923 (Address) Baltimore - Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park	12/14/23 19

20 UNDERTAKER ..... ADDRESS

H. E. Hughes, 424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify AS ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Slipped on floor at her Home.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1604 N. Gilmore St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David F. McMagus

(a) Residence No. 1604 Gilmore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Caroline McMann

6-DATE OF BIRTH (month, day and year): July 2 1891

7-AGE: 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Auto Mech
(b) General nature of industry, business, or establishment in which employed (or employer): Repairs
(c) Name of employer: do

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Bernard McMann

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Hannah O'Connell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Chas McManus
(Address): 1604 Gilmore St

15- Robert P. Harrison, Registrar.

C 131923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 13 1923

17- I HEREBY CERTIFY, That I attended deceased from April 3 1923 to Dec 13 1923

that I last saw h[illegible] alive on Dec 13 1923

and that death occurred, on the date stated above, at 3 30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F. Claude M. D.

Dec 13 1923 (Address) 15 N Mt Auburn

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: Dec. 14, 19 23

20-UNDERTAKER: Martin Fahey & Son — ADDRESS: 847 N Nath

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 81720 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 81720

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 215 — N — Mont ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucenda Peters

(a) RESIDENCE NO. 215 — N — Mont ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 - 1867 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Charles W. Brown

(Address) 1618 W. Mont

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

C 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1923, to Dec 12 1923,

that I last saw her alive on Dec 12 1923,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Mitral Stenosis

Mitral Insufficiency

(duration) 1 yrs. 10 mos. ? ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Urinalysis, Physical Signs

(Signed) H. W. Ritz M. D.

(Address) 1618 W. Mont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 15 1923
20 UNDERTAKER	ADDRESS
Sam'l. C. Rose	Woodmansee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81721 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 74001

CITY OF BALTIMORE: (No. 1012 W. Mosher St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Romulus Warren

(a) RESIDENCE NO. 1012 W. Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General) 10th
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Marcellus Blair
(Address) 1012 W. Mosher St.

15 Filed DEC 19 1923, 192 Robert P. Harrison, Registrar

[Burial Permit Clerk]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Pneumonia

(duration) yrs. mos. ds.

(Signed) J. C. Heuisler, M. D.
(Coroner.)

Dec. 13, 1923 (Address) 2807 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn — DATE OF BURIAL Dec 14 1923

20 UNDERTAKER Chas. W. Chase — ADDRESS Lauraville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81722

CERTIFICATE OF DEATH.

D 81722

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Coleman

(a) RESIDENCE No. 641 Raborg St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work O.K.

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER West Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Records 641 Raborg St

15 Filed C 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11/23 19

17

I HEREBY CERTIFY, That I attended deceased from 10/18/23, 19..., to 12/11/23, 19...,

that I last saw h alive on 12/11/23, 19...

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 2 yrs. mos 000 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

Cardiac Decompensation (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster	Dec 14 1923
20 UNDERTAKER	ADDRESS 1140
Dyson & Freeland	Lexington St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Luetic Probably

Spec—12-23-21—E.B.R.S.—400 Bks.

ALIMO

D 81723

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 81723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 133 W Camden St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Rose A Alimo

(a) Residence No. 133 W Camden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) SINGLE

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Apr 17-19

7-AGE, 6 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Vincent Alimo

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Florence Catanzaro

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy

14-

(Informant) Mr Vincent Alimo

(Address) 133 W Camden St

15-

Filed..... Robert P. Harrison, Registrar.

C 131923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 12th 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 19 23 to Dec 12 19 23

that I last saw h[illegible] alive on Dec 12 19 23

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

Mitral Regurgitation

(Duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ralph I Stright, M. D.

, 19 (Address) 26 E Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem

DATE OF BURIAL, Dec 15th 1923

20-UNDERTAKER. Per Edgar H Lord Per Jos F Cowan

ADDRESS 90 Hollins St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16819 D 81724 ✓ 101-001 D 81724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.** 7

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hooper

(a) RESIDENCE NO. 1000 Wolfe St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Foundry
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Josephine Coyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant
(Address) JOHNS HOPKINS HOSPITAL.

15 Robert F. Harrison, ... 19 .....
Registrar
Burial Permit Clerk.

C 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1923, to Dec 10, 1923
that I last saw h- alive on Dec 10, 1923,
and that death occurred, on the date stated above, at 3.30 a.m.
The CAUSE OF DEATH* was as follows:
Acute Lobar pneumonia (Pneumococcus II)

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Pericarditis + Empyema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Not Known.
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy.
(Signed) R. R Hannon, M. D.
12/12/23 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 14 1923
20 UNDERTAKER	ADDRESS
Thos Gerkhofer	406 W Conway

IMPORTANT—THIS STATEMENT RECORD. Every mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it ma TION is very important. See instructions on ba

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81725

CERTIFICATE OF DEATH.

46

D 81725

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120- 8th St Morrell Pk. ST.: 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva L. Floor

(a) RESIDENCE. NO. 1120- 8th St Morrell Pk ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. Floor

6 DATE OF BIRTH (month, day, and year) April 19th 1875.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. F. Allenbaugh.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Wilhelmine Christoph

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant C. Floor
(Address) 1120- 8th St. Morrell Park.

15 DEC 14 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Dec 11, 1923, that I last saw her alive on Dec 9, 1923, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No clinical

What test confirmed diagnosis?

(Signed) D. Wesley Strong, M. D.

(Address) 729 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Dec 14 19
20 UNDERTAKER Geo Leimbach & Son.	ADDRESS W. Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81726

101-001 ✓ ✓

CERTIFICATE OF DEATH.

D 81726

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 114 W Henrietta St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Blackwell

(a) Residence No..... 114 W Henrietta St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Blackwell

6-DATE OF BIRTH (month, day and year) Unk 1876

7-AGE, 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... NNN

(c) Name of employer.....

9-BIRTHPLACE (city or town), (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Nancy Randall

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Va

14-

(Informant) John Blackwell

(Address) 114 W Henrietta St

DEC 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 11 23

17- I HEREBY CERTIFY, That I attended deceased from Nov 30th, 1923, to Dec 11, 1923

that I last saw her alive on Dec 11, 1923

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical Signs

(Signed) D. F. Hancock, M. D.

12/13 1923 (Address) 140 W Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Arnika Cemetery	Dec 14, 1923
20-UNDERTAKER,	ADDRESS
John H. Toadvine	W Hill St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 81727

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 W. Barre ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Dorsey

(a) RESIDENCE NO. 521 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Dorsey

6 DATE OF BIRTH (month, day, and year) July-4-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work matching Goods

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Sonneborn.

9 BIRTHPLACE (city or town) Baltimore (State or country) maryland

PARENTS

10 NAME OF FATHER Francis C Dorsey

11 BIRTHPLACE OF FATHER (city or town) — (State or country) maryland

12 MAIDEN NAME OF MOTHER Elizabeth Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) maryland

14 Informant Mary E. Dorsey

(Address) 521 W. Barre St.

15 Filed DEC 14 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec, 10, 1923, to Dec, 11, 1923.

that I last saw h alive on Dec, 11, 1923.

and that death occurred, on the date stated above, at 5 P, m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis and Arteriosclerosis (duration) yrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no - urine neg.

What test confirmed diagnosis? bl pressure systolic 188

(Signed) Wm. Hamilton, M. D.

12/12 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec 14 1923

20 UNDERTAKER John H. Toadvine — ADDRESS [illegible]

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 81728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓ ✓

D 81728

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1411 W. Pratt ST., 19 WARD)

2-FULL NAME Benjamin H. Vernay

(a) RESIDENCE NO. 1411 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Varney.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shop Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. (State or country) Md.

PARENTS

10 NAME OF FATHER John Vernay

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret Bailey

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mary A. Vernay

(Address) 1411 W Pratt

15 Filed DEC 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1923, to Dec, 12, 1923, that I last saw him alive on Dec, 12, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bilateral Broncho Pneumonia.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. 2. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A. D. Driscoll M. D.

, 19 (Address) 1211 Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 15 1923
20 UNDERTAKER	ADDRESS
John J Foldo	1200 W Fayette

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81729

CERTIFICATE OF DEATH.

148 D 81729

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 136 N. Port St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Riggs

(a) Residence No. 136 N. Port St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frank E. Riggs

6-DATE OF BIRTH (month, day and year) Dec. 26, 1888

7-AGE. 39 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 837
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Alfred H. Davis

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sophie Schroeder

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country), Md.

14- (Informant) Frank E. Riggs
(Address) 136 N. Port St.

DEC 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from 12/13/23 19.. to 12/13/23 19..,
that I last saw her alive on 12/13/23 19..,
and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia (Hypostatic) Lungs
2 Hypostasis
2 20
3 4
.....(Duration) 1 day yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion Abdomen
.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard Stern, M. D.

12/14, 1923 (Address) 919 N. Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	Dec 17, 1923
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Pierce

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Benton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81730

CERTIFICATE OF DEATH.

38 D 81730

1-PLACE OF DEATH Boyview Hospital

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., No WARD)

2-FULL NAME William J Benton

(a) RESIDENCE NO. 709 S. Bouldin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Catherine Benton

6 DATE OF BIRTH (month, day, and year): May 9-1874

7 AGE: Years 48 Months 7 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Boyview Hosp.

15 Filed DEC 14 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1. 1921 to Dec 12 1923

that I last saw him alive on Dec 12 1923

and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (7th Chronic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Confusion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Hearings

(Signed) W. F. Schmidt M.D.

12/13 1923 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: 12/15 1923

20 UNDERTAKER: Gorkelar & Pickelar — ADDRESS: 1737 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 81731

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 845 N. 37th ST., 13 WARD)

2-FULL NAME Anna E. Parkes

(a) RESIDENCE No. 845 N. 37th. ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (h) HUSBAND of (or) WIFE of Charles E. Parkes

6 DATE OF BIRTH (month, day, and year) June 27-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	27	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Wm. M. Sprucebank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Sterling

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Charles E. Parkes

(Address) 845 N. 37th St.

15 Filed DEC 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11- 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1923, to Dec 11th, 1923.

that I last saw her alive on Dec 10th, 1923.

and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jno. Andrew Ward, M. D.

12/13/1923 (Address) 846 W 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Wards Hampden	Dec. 14 1923
20 UNDERTAKER	ADDRESS
Horace H. Burgee	3631 Falls Rd

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81732

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1822 North Durham St

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Emelia E Leban

(a) RESIDENCE NO. 1822 No Durham ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph E Leban

6 DATE OF BIRTH (month, day, and year) Dec 25, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER McConkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph E Leban
(Address) 1822 No Durham

15 DEC 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1923, to Dec 13, 1923,

that I last saw her alive on Dec 13, 1923,

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver ?

Influenza.

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W B Carman, M. D.

12-13-1923 (Address) 1707 N Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loriene — DATE OF BURIAL Dec 15 1923

20 UNDERTAKER Wm Cook — ADDRESS 502E Fdbal

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Died 1-50

129 D 81733

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 Font Hill Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Francis

(a) RESIDENCE No. 319 Font Hill Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Francis

6 DATE OF BIRTH (month, day, and year): Sept 10 1859

7 AGE: Years 74 Months 3 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Co Md

PARENTS

10 NAME OF FATHER: Isaac Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mariah Proctor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): James H. Francis 5307 St George Ave

15 Filed DEC 14 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/13/23, 19..., to 12/13/23, 19..., that I last saw him alive on 12/12/23, 19..., and that death occurred, on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Chr. Diff. Weight

Hypertension

Hypercholesterolemia ? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Neurasthenia (terminal) (duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Leonard L Long, M. D.

1923 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Towson — DATE OF BURIAL: Dec 15 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81734

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-01

D 81734

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1441 Lowman St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Suski

(a) Residence No. 1441 Lowman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 12, 1923

7-AGE. ....yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER. Andrew Suski

11-BIRTHPLACE OF FATHER (city or town). Poland
(State or Country),

12-MAIDEN NAME OF MOTHER. Victoria Zajac

13-BIRTHPLACE OF MOTHER (city or town). Poland
(State or Country),

11

(Informant). Andrew Suski

(Address). 1441 Lowman St.

Filed DEC 14 1923 192.... ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 13, 1923.

17- I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1923 to Dec. 13, 1923.

that I last saw him alive on Dec. 12, 1923

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ....yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? C. S. & S.

(Signed) John J. Kruger, M. D.

12/13, 1923 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL. Dec 15, 1923

20-UNDERTAKER. Wm Fallgowski

ADDRESS 618 Eastern Ave

Burial Permit Issued

This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81735

CERTIFICATE OF DEATH.

113 D 81735

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1238 Argyle Ave St.; 17 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Webb

(Residence in Baltimore: No. 1238 Argyle Ave St.; yrs., 1 mos. 7 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. Nov (Month) 6 (Day), 1923 (Year)

7-AGE.	If LESS than 1 day,
....yrs. 1 mos. 7 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. City

PARENTS.

10-NAME OF FATHER. J. H. Vaughn

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Annie Webb

13-BIRTHPLACE OF MOTHER (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Webb

(Address) 1238 Argyle Ave

15-

Filed ..... 191.... ROBERT B. KRAUTER, Registrar.

DEC 14 1923 Deputy Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12 (Month) (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Dec. 13 1923 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Iron	Dec 14 1923

20-UNDERTAKER Francis E. Duffy ADDRESS 1364 N. Carey

Spec.—1-10-21 - M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81736

CERTIFICATE OF DEATH.

D 81736

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 E. 32nd St., 9 WARD)

2-FULL NAME Carolyn Fisher

(a) RESIDENCE NO. 2001 E. 32nd St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Oct. 3. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	2.	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Lancaster, Pa.

10 NAME OF FATHER: Ernest J. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Amelia E. Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Ernest J. Fisher

(Address): 2001 E. 32nd St.

15 Filed DEC 14 1923 ROBERT R. KRAMES Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 13. 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1923, to Dec 13, 1923.

that I last saw h-- alive on Dec 13, 1923,

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Streptococcus Infection throat

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. C. Carlson M. D.

(Address) 701 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 14. 1923
20 UNDERTAKER	ADDRESS
Wm. H. Peufel & Son	804 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81737

CERTIFICATE OF DEATH.

197

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Josephs Hospital St., (or) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hudson

(a) RESIDENCE No. 1221 High Alley WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Hudson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 28	—	—	—

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laboner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Albert Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sallie Poudens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Sallie Taylor
(Address) Norfolk, Va

15 [illegible] 1923

DEC 14 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shot through

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Dec 13 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL Dec 15 1923

20 UNDERTAKER John A Henderson — ADDRESS 1501 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81738

D 81738

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1408 Cooksie St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Wengierski

(a) Residence No. 1408 Cooksie St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 9 1923

7-AGE. ... yrs. 7 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Hipolitw Wengierski

11-BIRTHPLACE OF FATHER (city or town) Pola nd
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary. Balzacka

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country),

14-
(Informant) Mr Hipolit. Wengierski
(Address) 1408 Cooksie Street

Filed DEC 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 14/23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 19 23 to Dec 17 19 23
that I last saw h— alive Dec 11 19 23
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:

Acute Intramural Pneumonia about 3 days
(Duration) ... yrs. ... mos. 3 ds.
CONTRIBUTORY (Secondary) Acute Endocarditis
(Duration) ... yrs. ... mos. 3 ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of .....
Was there an autopsy? —
What test confirmed diagnosis? .....
(Signed) H. J. Marx M. D.
12. 14. 1923 (Address) 801 E. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Dec. 15, 1923
20-UNDERTAKER,	ADDRESS
John A. Weber	1803 Bank St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81739

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 4/5 81739 ✓

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD).

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Williams

(a) RESIDENCE NO. Port Depart ST., WARD Port Deposit

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18—1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamship Captain

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Fredericktown
(State or country) Md.

PARENTS

10 NAME OF FATHER George W. Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Rebecca Whittel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Cecilia Hewett
(Address) 527 So Bayard st.

15 DEC 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923 to 12-1, 1923, that I last saw him alive on 12-11, 1923, and that death occurred, on the date stated above, at 12:50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas
Glands.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 15, 1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fredericktown Md	Dec 11 1923
20 UNDERTAKER Harry H. Witzke	ADDRESS 153 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81740

CERTIFICATE OF DEATH.

57 D 81740

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. (Mamie) Dorn Schussler

(a) RESIDENCE NO. 217 E. 33rd ST., ~~33~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Adam Schussler

6 DATE OF BIRTH (month, day, and year) June 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Busby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Adam Schussler

(Address) 217 E. 33rd St - city

15 Filed DEC 14 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov., 28, 1923, to Dec., 13, 1923, that I last saw her alive on Dec., 13, 1923, and that death occurred, on the date stated above, at 12:18 P m.

The CAUSE OF DEATH* was as follows:

Meningitis (Pneumococcus)
following otitis + Mastoiditis
of 30 days duration

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Otitis + Mastoiditis — Diabetes mellitus first 50

(duration) 0-1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of Dec. 5, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Pathology

(Signed) Guy Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 12/15 1923

UNDERTAKER Chas. F. Wane + Son 118 W. Mt. Royal Ave — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81741

CERTIFICATE OF DEATH

75-6b 81741

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Wilson

(a) RESIDENCE NO. 100 N. Eden St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 07D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard ~~Wilson~~ Robison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital, Records. (Address)

15 Filed DEC 14 1923 ROBERT R. KRAUT, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 17 1923 to December 11 1923, that I last saw her alive on December 10, 1923, and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Left Hemiplegia (Residual)

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (terminal) (duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Drane, M. D.

12-12-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashburn Cemetery	Dec 14 1923

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 1720 Eastlands

N. B.—WHETHER FILLED WITH UNDERTAKER OR PHYSICIAN—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81742

CERTIFICATE OF DEATH.

129 D 81742

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1124 Hollins St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... William G. Frobish

(a) Residence No.... 1124 Hollins St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): March 11 1858

7-AGE: 65 yrs. 9 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Weaver of

(b) General nature of industry, business, or establishment in which employed (or employer): stockings

(c) Name of employer: (self)

9-BIRTHPLACE (city or town): Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Gottlieb Frobish

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Eichorn

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14-
(Informant) Miss Annie Frobish

(Address) 1124 Hollins Street

15-Filed DEC 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 12, 1923

17-I HEREBY CERTIFY, That I attended deceased from Dec 4 '23, to Dec 12 '23,

that I last saw h[illegible] alive on Dec 11 '23,

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Asthenia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

(Duration) yrs. ? mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

12-12, 1923 (Address) 1302 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Dec 14, 1923
20-UNDERTAKER, Jos L. B. Cook	ADDRESS 1003 N. Dallas

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81743

CERTIFICATE OF DEATH.

74-001

D 81743

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 E Lafayette Ave ST., 8 WARD)

2-FULL NAME Elizabeth D. Millican.

(a) RESIDENCE NO. 1616 E Lafayette Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 11 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know.

6 DATE OF BIRTH (month, day, and year) Jan 9-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... At home

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Saml Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va Md

12 MAIDEN NAME OF MOTHER Mary A Conf. Dec 13 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mollie D. Fress.
(Address) 1616 E Lafayette Ave

15 DEC 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1923, to Dec 13 1923, that I last saw h[illegible] alive on Dec 12 1923, and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis & Right Side Hemiplegia

(duration) 37 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J Morton Thomas, M. D.

(Address) 1218 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL Dec 15 1923

20 UNDERTAKER John Sullivan — ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81744

CERTIFICATE OF DEATH.

164 D 81744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Central Ave ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Hirtz

(a) RESIDENCE NO. 928 N. Central Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
In her	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Anna Gallis.
(Address) 928 N. Central Ave

15 Date DEC 14 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1923, to Dec. 13, 1923, that I last saw her alive on Dec. 13. 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Senile debility.

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Old age.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. J. Lebud, M. D.

. 19 (Address) 1001 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 15 1923
20 UNDERTAKER Henry Horch Son	ADDRESS 1301 Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81745

CERTIFICATE OF DEATH.

90 D 81745

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1126 Aisquith ST., 10 WARD)

2-FULL NAME Amanda M. Stirkwell

(a) RESIDENCE NO. 1126 Aisquith ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? 67 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Stirkwell

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE — Years: 67 — Months: — — Days: — — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: H. T. Koerner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. J. E. Danekker (Address) 1620 N. Caroline St.

15 Filed ....., 19..... Registrar

DEC 14 1923

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 13, 1923, that I last saw her alive on Dec 12, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Gill Hall, M. D.

Dec 14 1923 (Address) 631 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec. 15 1923

20 UNDERTAKER: Henry Hoerdt Son — ADDRESS: 1301 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81746 HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 ✓ ✓

CERTIFICATE OF DEATH.

D 81746

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 W 33 ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy M Blucher

(a) RESIDENCE NO. 611 W 33 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ ✓

6 DATE OF BIRTH (month, day, and year) Apl 23 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER John M Blucher

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary A Burkett

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Robert Blucher (Address) 611 W 33 St

15 Filed DEC 14 1923 19 ROBT. R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Dec 13, 1923, that I last saw h[illegible] alive on Dec 13, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.

(duration) 5 yrs. + mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. B. Normal M. D.

(Address) 854 2 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Dec 17 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

Spec.—1-10-21—M&T—1500 Bks.

D 81747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81747

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25 WARD)

2-FULL NAME Robert M. Walter

(a) RESIDENCE NO. Fauquier Md ST., WARD

(Usual place of abode)

Length of residence in city or town where died ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Oct 21, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocerman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James M Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Surry Co Va

12 MAIDEN NAME OF MOTHER Mary E. Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs W Miller

(Address) 1012 Hollins St

15 Filed ... 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1923 to Dec 13 1923, that I last saw h... alive on Dec 13 1923, and that death occurred, on the date stated above, at 840 A.M.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Infected arm

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10th 12th

Was there an autopsy? No Lab

What test confirmed diagnosis?

(Signed) H. Harper, M. D.

(Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 15, 1923
20 UNDERTAKER	ADDRESS
Wm. J. Fickus, Sons	North Ave

DEC 14 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81748

CERTIFICATE OF DEATH.

D 81748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3941 Greenmount ave ST. 9th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriam C. Foutz

(a) RESIDENCE. NO. 3941 Greenmount ave ST., 9th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Soloman A. Foutz

6 DATE OF BIRTH (month, day, and year) March 24th 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Warfieldsburg Carroll Co, Md.

PARENTS

10 NAME OF FATHER J. E. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warfieldsburg Carroll Co, Md.

12 MAIDEN NAME OF MOTHER Mary Root.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warfieldsburg Carroll Co, Md.

14 Informant Hervey G. Foutz.
(Address) 36 Evergreen Ave, Hamilton, Md.

15 Filed DEC 14 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1923, to Dec 12, 1923, that I last saw h alive on Dec 12, 1923 and that death occurred, on the date stated above, at 9.40 P. M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Greenken M. D.

Dec 13, 1923 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 15 1923

20 UNDERTAKER	ADDRESS
E. A. Windsfeld Jr	601 E 22 St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81749

CERTIFICATE OF DEATH.

X45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Emmerich

(a) RESIDENCE NO. West River Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Emmerich

6 DATE OF BIRTH (month, day, and year) 12-26 1880

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Emmerich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Adelbert Myers

(Address) 3102 Sutton St.

15 Filed Robert P. Harrison Registrar

Burial Permit Clerk

DEC 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-13 1923 to 12-14 1923

that I last saw him alive on 12-14 1923,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Thrombosis of superior mesenteric Artery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) diffuse peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12-13 23

Was there an autopsy? yes

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount A. A. C. Md. DATE OF BURIAL Dec 15 1923

20 UNDERTAKER John A. Mitchell ADDRESS 1201 W. Fayette St.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OBSTETRICAL TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81750

D 81750

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 543 W. Lafayette ave ST., 17 WARD)

2-FULL NAME Hanson Hughes

(a) RESIDENCE NO. 543 W. Lafayette ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jamie Hughes

6 DATE OF BIRTH (month, day, and year) about 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer Dr. Likes

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Hanson Hughes

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Jennie Hughes
(Address) 543 W. Lafayette ave.

15 Filed DEC 14 1923, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. C. S. Hennessy, M. D.
(Coroner)

Dec. 14, 1923 (Address) 2802 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Md. DATE OF BURIAL 12/16 1923

20 UNDERTAKER James H. Wenner ADDRESS 303 Mitchell

DEC 14 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81751

CERTIFICATE OF DEATH.

46 D 81751

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1452 n. caey ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C Johnson

(a) RESIDENCE. NO. 1452 n. ebey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE: Years 54 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Stalls

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ethel Johnson (Address) 1452 N. Ebey St

15 Filed , 19 Robert P. Harris Registrar

DEC 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13- 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Dec 13, 1923, that I last saw h. alive on 12/13-, 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Fibroid Tumor

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Goitre

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Boykin, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12/15 1923
20 UNDERTAKER James H. Dennis	ADDRESS 343 Rutland

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

of Vocal Malignant

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81752

CERTIFICATE OF DEATH.

74-001 D 81752

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Woodyear Place ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Henson

(a) RESIDENCE No. 1703 Woodyear Place ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Henson

6 DATE OF BIRTH (month, day, and year) — 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress at Home

(b) General nature of Industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Prince King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Alethia — Dec 13, 1926

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Thomas Henson
(Address) 1703 Woodyear Pl

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1923, to Dec 13th, 1923, that I last saw her alive on Dec 12th, 1923, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ..... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 1703 Woodyear Pl

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E. Mackenzie, M. D.

(Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 12/15 1923

20 UNDERTAKER James H. Dennis — ADDRESS 305

FEB 14 1924

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81753

D 81753

CERTIFICATE OF DEATH.

1114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 N. Mount St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lettie Johnson

(a) RESIDENCE. NO. 1630 N. Mount ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years 47 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Mount Rust

PARENTS

10 NAME OF FATHER Not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Mrs. Johnson 1630 N. Mount St

15 Filed ....., 19 .....

Robert F. ..... Registrar

EC 14 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-13-1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 23 19..., to Dec 13, 1923, that I last saw her alive on 12-13-, 1923, and that death occurred on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Gastritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Loss of teeth

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Dayton, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 12/17 1923

20 UNDERTAKER Jas. H. Dennis — ADDRESS 1303 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

No other history

Spec.—1-10-21—M&T—1500 Bks.

D 81754

HEALTH DEPARTMENT—CITY OF BALTIMORE

54 D 81754

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

2-FULL NAME Mrs. Mary Spicer

(a) RESIDENCE NO. 409 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? [redacted] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Hugh Mockbee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Earley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Ireland

14 Informant Miss Moran

(Address) 409 Park Ave

15 Filed [illegible] 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-12- 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-1- 1923, to 12-12 1923,

that I last saw her alive on 12-12 1923,

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 Address St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fallston Md

DATE OF BURIAL Dec 15 19 23

20 UNDERTAKER M Tracey & Son

ADDRESS [redacted]

C 14 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81755 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 81755

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp, St., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bowman

(a) RESIDENCE NO. 1210 Druid Hill Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rivoli Theater

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER [illegible] Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER [illegible] Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Bessie Jones

(Address) 115 N Eutaw St

15 Filed ....., 19.... Robert P. [illegible]

Registrar

DEC 14 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th 1923 to Dec 12 1923 that I last saw him alive on Dec 12 1923, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

general peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-10-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Monninger M. D.

12-12 1923 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	12-16 1923
20 UNDERTAKER	ADDRESS 915
Dan'l Easton	Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81756

CERTIFICATE OF DEATH.

101-80

1-PLACE OF DEATH 2007 Eagle St.,

CITY OF BALTIMORE: (No. " " " St., 20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Kessler

(a) RESIDENCE NO. 2007 Eagle St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.,

PARENTS

10 NAME OF FATHER Edward J. Kessler

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.,

12 MAIDEN NAME OF MOTHER Maryl Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.,

14 Informant Edward J. Kessler (Address) 2007 Earle St.,

15 Filed DEC 4 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 3- , 1923, to Dec. 13- , 1923, that I last saw him alive on Dec. 13- , 1923, and that death occurred, on the date stated above, at 10 45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Endocarditis & Pulmonary edema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dudley P. Bowie, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 15 1923

20 UNDERTAKER Harry N. Witzke ADDRESS 1531 W. Lombard

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81757

30

5

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 5 WARD)

2-FULL NAME Etta Nicholson or Cora

(a) RESIDENCE No. 1615 Mulliken St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 19 23

17

I HEREBY CERTIFY, That I attended deceased from October 9, 19 23, to December 11, 19 23,

that I last saw her alive on December 11, 19 23,

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Mycosis

(duration) ... yrs. 8 mos (Rickey) ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lab + Autopsy

(Signed) Claude A. Thomas M. D.

12-12-23 19 (Address) Municipal Hospital.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Dec 15th 1923
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden st

DEC 15 1923

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81758

181-001

D 81758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 741 W Lexington St., ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew J Colton

(a) RESIDENCE NO. 741 W Lexington St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath Md

PARENTS

10 NAME OF FATHER John Colton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz Crist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elig Simpson
(Address) 741 W Lexington St

15 Filed ..... 192 ..... Robert P. Garrison, Registrar

EC 15 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

12-13 , 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Dec 15 1923

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81759 ✓ D 81759

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2804 N. Calvert St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jane Shamberger

(a) Residence No. 2804 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Shamberger

6-DATE OF BIRTH (month, day and year): June 6, 1848

7-AGE: 75 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Lyons Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Martha J. Hendrix

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-(Informant) Julia E. Shamberger

(Address) 2804 N. Calvert St.

15-

Filed ..... 192.....

Registered Robert P. Harrison, Burial Permit Clerk

DEC 14 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 14-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1923 to Dec 14th, 1923, that I last saw h.r alive on Dec 14th, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock from sons death

Age (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Urine

(Signed) D. A. Waldron, M. D

, 19 (Address) 210 East Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. — DATE OF BURIAL, Dec 17 1923

20-UNDERTAKER: Jos. Mitchell — ADDRESS 1201 W. Fayette St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. WRITE PLAINLY. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81760

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2323 Eastern ST., 1 WARD)

2-FULL NAME Augusta Rauh

(a) RESIDENCE No. 2323 Eastern Ave ST., 1 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Geo. Rauh.

6 DATE OF BIRTH (month, day, and year) Jan 28th 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicholas Behner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Leona Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Carrie Insley Daughter
(Address) 2323 Eastern Ave.

15 DEC 15 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1923, to Dec 14 1923, that I last saw h[illegible] alive on Dec 10 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

.....

.....

(Duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. C. Bridges, M. D.

(Address) 1436 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state 1) Means and Nature of Injury, and 2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL Dec. 17 1923

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81761 HEALTH DEPARTMENT—CITY OF BALTIMORE 89 D 81761

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH 2736 St Paul St

City of BALTIMORE: (No. ..... St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund C White

(a) Residence No. 2736 St Paul St St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alice R White

6-DATE OF BIRTH (month, day and year) Feb 15, 1861

7-AGE. 62 yrs. 10 mos. ..... ds. If LESS than 1 day, ...hrs. or, ...min.?

8-OCCUPATION OF DECEASED Cangood Packer

(a) Trade, profession, or particular kind of work, Can Mfr

(b) General nature of Industry, business, or establishment in which employed (or employer) H W Boyer Co

(c) Name of employer President

9-BIRTHPLACE (city or town) Cleveland (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Lambert White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Mary ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14- (Informant) Alice R White

(Address) 2736 St Paul St

15- Filed DEC 15 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 14. 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 30 19 23 to Dec 14 19 23

that I last saw him alive on Dec 14 19 23

and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McAlester, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet — DATE OF BURIAL, DEC 17, 1923

20-UNDERTAKER. [illegible] — ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81762

CERTIFICATE OF DEATH.

114 D 81762

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 N. Bentalou St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Lee

(a) RESIDENCE NO. 523 Baker St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Hannah Holland
(Address) 1714 Gilmore St.

Filed DEC 15 1923, 192 Robert P. Harrison, Registrar
[Burial Permit Clerk.]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

acute Gastro enteritis

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ac. Delirium Tremens

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)
Dec 14 1923 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt. Lookout	Dec 15 1923
20 UNDERTAKER Samuel Hendley	ADDRESS 1118 E. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81763

CERTIFICATE OF DEATH.

1929 D. 81763

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 63 E Forest View Ave ST. Belvar. (WARD) No

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthias Woessner

(a) RESIDENCE NO. 53 E Forest View Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Woessner

6 DATE OF BIRTH (month, day, and year) Dec 28 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Andrew Wessner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ernst Frank

(Address) 53 E Forest View Ave

15 Filed DEC 17 1929, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Dec 13, 1923, that I last saw h alive on Dec 13, 1929, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows: 5

Hypostatic Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster M. D.

, 19 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Dec 17 1929

20 UNDERTAKER John Ulrich — ADDRESS 209 E Pream

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 17 1929

Spec.—1-10-21—M&T—1500 Bks.

Hackmann

D 81764 HEALTH DEPARTMENT—CITY OF BALTIMORE 21 D 81764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1341 Ramsey ST. 19 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Hackmann

(a) RESIDENCE No. 1341 Ramsey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hackmann

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
45	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sail Fabricator Man

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer Heath Bros 886 Balto

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry H Hackmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Kroeker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Hackmann

(Address) 1341 Ramsey St

15 Filed DEC 15 1923, 19 Robert F. Karpisch, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 1923, to Dec 14, 1923, that I last saw him alive on Dec 13, 1923, and that death occurred, on the date stated above, at 5.25 A m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Dysell M. D.

12/14, 19 23 (Address) 105 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Dec 17 1923

20 UNDERTAKER Knell & Son 1789 W Pratt — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 S 12 ~~81765~~ Salary

94 D 81765

REGISTERED NO.

1-PLACE OF DEATH: JOHNS HOPKINS H'SPITAL.

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Chepulis

(a) RESIDENCE No. North Point Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 15 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie Chepulis

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER Antonio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ..... (Address) JOHNS HOPKINS H'SPITAL.

15 Filed ..... DEC 15 1923 ....., 19 ..... Registrar

Robert F. Harrison, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1923, to Dec 14, 1923, that I last saw h[illegible] alive on Dec. 14, 1923, and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Septicaemia following lymphangitis and gangrene left arm

(duration) ..... yrs. 1/2 mos. ..... ds.

CONTRIBUTORY (Secondary) Septicaemia Streptococcus

(duration) ..... yrs. 1/2 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec. 3 '23

Was there an autopsy? No

What test confirmed diagnosis? Culture & Section Pathological Lesion

(Signed) J. A. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dead Heart Cem.	Dec 15 19 23
20 UNDERTAKER	ADDRESS
Jacob Pentowski	1258 S. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Could get no other History.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81766

CERTIFICATE OF DEATH.

101-001

D 81766

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Williams ST., ... WARD) 7

2-FULL NAME Alice Saunders

(a) RESIDENCE NO. 1704 Williams ST., ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark, Md.

PARENTS

10 NAME OF FATHER George Riley

11 BIRTHPLACE OF FATHER (city or town) Newark (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Waters

13 BIRTHPLACE OF MOTHER (city or town) Newark (State or country) Md

14 Informant Lilly Holland

(Address) St Martins Md

15 Filed ..., 19...

Robert F. Harris

Registrar

Burial Permit Clerk.

DEC 15 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13/23 19

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1923, to Dec 13, 1923,

that I last saw her alive on Dec 13, 1923,

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Yes

(Signed) Lilly L Logue, M. D.

12/14/1923 (Address) 709 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Martin's Md.	12/15 1923
20 UNDERTAKER	ADDRESS
Jas. Jr. Skinner	1625 Orad St

Spec.—1-10-21—M&T—1500 Blks.

D 81767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81767

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 S. Bethel ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Woods

(a) RESIDENCE No. 18 S. Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Woods

6 DATE OF BIRTH (month, day, and year) Dec 11 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Dusty

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Irene Butler
(Address) 2121 Eutaw Place

15 Filed DEC 15 1923, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1923 to Dec 13 1923,

that I last saw h alive on Dec 12 1923,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address) 1514 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — DATE OF BURIAL Dec 15 1923

20 UNDERTAKER John W Henderson — ADDRESS 1304 E Monument

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81768

D 81768

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Hollins St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Dugan

(a) RESIDENCE NO. 2024 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Dugan

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker 6 8

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Dugan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katie Dugan

(Address) 2024 Hollins St.

15 DEC 15 1923, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1923 to Dec. 14, 1923, that I last saw him alive on Dec. 14, 1923, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of "

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D.

12/15 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 17 1923
20 UNDERTAKER	ADDRESS
Geo J. Smith	1000 Fayette St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-06 D 81769

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Fulcher or Fisher

(a) RESIDENCE NO. 808 Pratt St W. ST., (Rooms house) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Police Dept
(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

DEC 15 1923 0960

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

Dont know (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Ruby 1037 Penn, M. D.
(Coroner.)

Dec 14. 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State I know about yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: DEC 15 1923

20 UNDERTAKER: Commissioner Health, — ADDRESS

per. Wm. E. Woodall.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 81770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D 81770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ward

(a) RESIDENCE No. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1921 to December 7, 1923, that I last saw him alive on December 6, 1923, and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronch-Pneumonia

(Immed.) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext

(Signed) Claude A. Draper, M. D.

12-7 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL DEC 15 1923

20 UNDERTAKER Commissioner Health,

ADDRESS

BY WM. E. WOODALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 346 Fayette Ave. ST. 70 WARD)

REGISTERED No. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Edward Driscoll

(a) RESIDENCE. No. 346 Fayette Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 1923

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.
	0	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Raymond F. Driscoll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Ida Crossen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Raymond F Driscoll
(Address) 346 Fayette Ave

15 Filed DEC 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14 9. m., 1923, to Dec. 14 9.30 p. m. 1923.

that I last saw h.m alive on Dec. 14 1923

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank A. Hillis, M. D.

Dec 15. 1923 (Address) 2838 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: DEC 15 1923

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

DEC 15 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81772 ✓ D 81772

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) 12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David goldberg

(a) RESIDENCE NO. 1818 Wallbrook ave (ST.) (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1 - 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Louis goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Berda Weiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Record
(Address)

15 Filed . 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1923, to Dec 14, 1923, that I last saw him alive on Dec 14, 1923, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria bacillus, pharyngeal & laryngeal
(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) myocarditis
(duration) yrs. mos. 4? ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? cultures.

(Signed) P. MacPherson, M. D.

12/15/23 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edgewood Cemetery	Dec. 15 1923
20 UNDERTAKER	ADDRESS
Jack Levin	1429 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 15 1923

Cor.—1-12-23—M&T—100 Blks.

D 81773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 185

D 81773

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital 7 WARD)

2-FULL NAME Anthony Van Pelt

(a) RESIDENCE No. Jones Creek Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of fore-gn birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct 13/1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Retired Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John Van Pelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Hannah Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Pa.

14 Informant R. Emmett Van Pelt
(Address) 318 E. Hamburg St.

15 Filed DEC 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Perotinitis -2 days
(History of falling & fracturing ribs & other injury-2 weeks previous- accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Fallon, M. D.
(Corner.)

Dec 15/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Toledo Ohio Via P.R.R. DATE OF BURIAL Dec 15 1923

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23--M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81774

CERTIFICATE OF DEATH.

90 D 81774

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ashland Ave & 14th ST., Orangeville 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morgie W. West

(a) RESIDENCE NO Ashland Ave. & 14th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip R. West

6 DATE OF BIRTH (month, day, and year) Feb 24/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co. Md
(State or country)

PARENTS

10 NAME OF FATHER David Durham

11 BIRTHPLACE OF FATHER (city or town) Harford Co. Md
(State or country)

12 MAIDEN NAME OF MOTHER Dorcas WOOD

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Philip R. West
(Address) 927 N. 10th St. Orangeville

15 DEC 16 1923 ROBERT R. KRAUTER Registrar
Filed Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilatation

(duration) ....yrs. ....mos 6 ds.

CONTRIBUTORY (Secondary) Acute Indigestion.

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Paul, M. D.
(Coroner.)

Dec 15/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loretta Cemetery Cat. Md le W. Nottingham Friends Cemetery	Dec 17th 1923
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E. Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.R.S.—400 Bks.

Brumback 1531 E. Fort Ave

D 81775 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 34 D 81775

1-PLACE OF DEATH. Registered No.

City of BALTIMORE: (No. 1735 Aisquith St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emory H. Brown

(a) Residence No. 1735 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 25 1905

7-AGE. 18 yrs. 3 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER. E. Allen Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER. Katie Horel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-

(Informant) E. Allen Brown

(Address) 1735 Aisquith St

15- DEC 16 1923 16- ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 15 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1923 to Dec. 14, 1923

that I last saw him alive on Dec. 14, 1923,

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Brumback M. D.

12-15-23 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore DATE OF BURIAL, Dec. 17, 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E. N. Ave

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81776

CERTIFICATE OF DEATH.

90

REGISTERED NO. D 81776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Thalheimer

(a) RESIDENCE NO. Eutaw Pl. ST., Lake Drive WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kaufman Thalheimer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
91	✓			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Sigmund Thalheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant: Sanders Thalheimer (Address) Esplanade Apts

15 Filed DEC 16 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1922 to Dec 1923.

that I last saw h. alive on Dec 14 1923,

and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lutz, M. D.

14/15 1924 (Address) 20 E Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship — DATE OF BURIAL 12/16 1923

20 UNDERTAKER J. AHRENS & CO. FUNERAL DIRECTORS AND EMBALMERS 16th & MADISON AVENUE — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81777

CERTIFICATE OF DEATH.

31 D 81777

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 S 2nd ST., 26 WARD)

2-FULL NAME Hazel E Kalb

(a) RESIDENCE NO. 817 S 2nd ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matthew E Kalb

6 DATE OF BIRTH (month, day, and year) Feb 18 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER William Le Compte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Cro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Matthew E Kalb

(Address) 817 S 2nd St

15 Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to Dec 13 1923.

That I last saw h alive on Dec 10, 1923,

and that death occurred, on the date stated above, at 2.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 1 yrs. mos ds.

CONTRIBUTORY (Secondary) " " "

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4 1818, Balt

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Heller M. D.

12 13, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cem.	Dec 17 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81778

CERTIFICATE OF DEATH.

49 D 81778

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 S. Fourth St. ST., 76 WARD)

2-FULL NAME Frank F. Schumann

(a) RESIDENCE NO. 804 S. Fourth St. ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8- 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended

(b) General nature of industry, business, or establishment in which employed (or employer) School.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Albert R. Schumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Anna Erb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Albert R. Schumann (Address) 804 S. Fourth St.

15 Filed DEC 16 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1923.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1923, to Dec 12, 1923.

that I last saw him alive on Dec. 12, 1923,

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Femur

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Generalized Metastases

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank A. Hanta, M. D.

Dec 13 1923 (Address) 3744 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Dec. 16 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

81778 16835 104 m

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002

D 81779

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Thomas Snyder

(a) RESIDENCE No. 7 St. Edmonds Pl ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 14 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Harry C. Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Stonia Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 16 1923, 19 WILLIAM R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 - 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/9/23, 19 ..... to 12/15, 1923, that I last saw him alive on 12/15, 1923, and that death occurred, on the date stated above, at 10:50 m.

The CAUSE OF DEATH* was as follows:

Dysentery, Bacillary (type undetermined)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cultivation of B. dysenteriae, type determination not completed

(Signed) Langdon Jackson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	Dec. 17 1923
20 UNDERTAKER Tilly & Zeiler	ADDRESS 403 W Fay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81780 — CERTIFICATE OF DEATH — 101-001 — D 81780

1-PLACE OF DEATH: Hebrew Hospital — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ..... ST., 27 (WARD)

2-FULL NAME: Samuel Sody

(a) RESIDENCE NO. 5120 Wilson Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Sody

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

(c) Name of employer: O & S

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Hyman Sody

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: S. Lewis
(Address): 1439 E. Baltimore St.

15 Filed DEC 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12th, 1923, to Dec. 16th, 1923, that I last saw him alive on Dec 16th, 1923 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Edema

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidor L. Fry, M. D.

Dec. 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen's Circle Mt. Carmel	Dec 16 1923
20 UNDERTAKER: Jacob Lewis, 1439 E. Balto. St.	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

77 D 81781

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. ... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Hill

(a) RESIDENCE NO. 107 N. Dallas ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Summerfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Bay View Hosp.

15 DEC 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923 to Dec 12, 1923.

that I last saw h— alive on Dec. 12 1923

and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Mania Depression Pay Crisis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy findings

(Signed) N. Feldman, M. D.

17/13 Eastern Ave (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	dec 17 1923
20 UNDERTAKER	ADDRESS 631
Edward Bryan	Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81782

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2555 Edmondson Ave ST. 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bodie Eyre Brown

(a) RESIDENCE NO. 2555 Edmondson Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lincoln R. Brown

6 DATE OF BIRTH (month, day, and year): July 16 1874

7 AGE — Years: 49 — Months: 4 — Days: 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York, N.Y.

PARENTS

10 NAME OF FATHER: John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Mary Eyre

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Douglas Brown

(Address): 2555 Edmondson Ave

15 FILED DEC 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 14 1923

17 I HEREBY CERTIFY, That I attended deceased from several years, 19..... to Dec. 14, 19 23.

that I last saw h[illegible] alive on Dec. 14, 19 23,

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation of Heart

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) F. Labrie Ewell, M. D.

Dec 16, 1923 (Address) 2945 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Dec 17 1923

20 UNDERTAKER: Wm J Rickert Sons.

ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31783

CERTIFICATE OF DEATH.

101-001 ✓ D 31783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3001 Clifton Ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maude Owings

(a) RESIDENCE No. 3001 Clifton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Owings

6 DATE OF BIRTH (month, day, and year) Sept 27, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 31

(c) Name of employer

9 BIRTHPLACE (city or town) Lisbon
(State or country) Md.

PARENTS

10 NAME OF FATHER C. D. Henderson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Alberta Burgess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant M. Clarence Owings
(Address) 3001 Clifton Ave.

15 DEC 16 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1923, to Dec. 14, 1923.

that I last saw her alive on Dec 14, 1923

and that death occurred, on the date stated above, at 9.10 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. C. Adkins, M. D.

12/16/23 (Address) 2757 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 17 1923
20 UNDERTAKER Wm J. Beckwith & Sons	ADDRESS North St.

Kunigunda Kopp

Spec--12-23-21—E.B.R.S.—400 Bks.

81784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 81784

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 128 S. Washington St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Kunigunda Kopp

(a) Residence No. 128 S. Washington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (~~Write the word.~~) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Kopp

6-DATE OF BIRTH (month, day and year) Nov 21 1848

7-AGE, 75 yrs. mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Fleischman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Mary Linn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Henry S. Kopp

(Address) 128 S. Washington

15-

Filed DEC 16 1923 (By) Burial Permit Clerk.

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 13 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1923 to Dec 13 1923

that I last saw h.. alive on Dec 13 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

12-16, 1923 (Address) 1937 Gough St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. December 18 1923

20-UNDERTAKER. Wendell Ryffel & Son — ADDRESS 378 Linn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81785

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... St. University Hospital WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Carter

(a) RESIDENCE NO. Ellicott City, ST. Maryland WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Austin Carter

6 DATE OF BIRTH (month, day, and year): 8/10/94

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	4	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Cary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant ..... (Address) Records University Hospital

15 Filed DEC 16 1923 19 ..... Registrar

ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/15 19 23.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1923, to Dec. 15, 1923,

that I last saw her alive on Dec. 15, 1923,

and that death occurred, on the date stated above, at 9.40 A.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever
Broncho pneumonia

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Ellicott City, Md.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Inspection, Blood Culture

(Signed) W. Wallace Weller, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Chapel Cem. Co. — DATE OF BURIAL: Dec. 17 1923

20 UNDERTAKER: Easton Sons — ADDRESS: Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81786

CERTIFICATE OF DEATH.

129

D 81786

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Scott st ST., 21 WARD)

2-FULL NAME Charles. W. Burns

(a) RESIDENCE NO. 505 Scott st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1858

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Emerson Drug Co

9 BIRTHPLACE (city or town) (State or country): Elkridge md

PARENTS

10 NAME OF FATHER: William Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Dent Kent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Frank. F. Connelly

(Address): 505 Scott st

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Registrar

DEC 16 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1923, to Dec 14 1923, that I last saw him alive on Dec 13 1923, and that death occurred, on the date stated above, at 1 40 m.

The CAUSE OF DEATH* was as follows:

Arterio. Sclerosis -

(duration) — yrs. 5 mos 4 ds.

CONTRIBUTORY (Secondary): Unknown -

(duration) — yrs. 4 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1923 (Address) 504 Scott st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery Elkridge	Dec 17 1923
20 UNDERTAKER: Fos Joerden & Son	ADDRESS: 217 S. Pea

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Blk.

D 81787 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1 x 90 D 81787

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Ag Hospital ST., 25 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry D Moffett

(a) RESIDENCE NO. Richmond Va ST., — WARD —
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1884 Inquiry

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St Louis
(State or country) Missouri

PARENTS

10 NAME OF FATHER Henry Albert

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Jennette Kraft

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs Jennette Albert
(Address) 2512 Wisconsin ave Washington D.C.

15 Filed DEC 7 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Mitral Stenosis

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. ds.

(Signed) Geo Edwin Blades, M. D.
(Coroner.)
Dec 16 1923 (Address) 143 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Dec 17 1923

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81788

HEALTH DEPARTMENT—CITY OF BALTIMORE

Paxton

D 81788

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2108 E Hoffman St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Paxson.

(a) Residence No. 2108 E Hoffman St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Paxson

6-DATE OF BIRTH (month, day and year) FEB 2nd 1868

7-AGE.	If LESS than 1 day,
55 yrs. 10 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Wisconsin

PARENTS.

10-NAME OF FATHER, not known.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country),

14- (Informant) Andrew Paxson

(Address) 2108 E Hoffman

15- Filed DEC 17 1923 ROBERT R. KRAUTER Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 15-1923

17- I HEREBY CERTIFY, That I attended deceased from July 30 1923 to Dec 15 1923

that I last saw h.. alive on Dec. 12 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(Medical Registration)

(Duration) yrs. mos. ds.

CONTRIBUTORY Asthenia

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lillian Frazer M.D.

(Address) 1407 W Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Arlington Cem. Va.	12-19, 1923
20-UNDERTAKER.	ADDRESS
Wm Chas A Y Rohde	600 N Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81789

CERTIFICATE OF DEATH.

139 D 81789

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice G. Powell

(a) RESIDENCE NO. 244 N. Pine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Powell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jas Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ellen Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Sophia Hargrove

(Address) 134 S. Carey St.

15 Filed DEC 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1923, to Dec. 13, 1923, that I last saw her alive on Dec. 13, 1923, and that death occurred, on the date stated above, at 6:15 a. m.

The CAUSE OF DEATH* was as follows:

Necrotic Fibroids Uterus.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 12-13-23.

Was there an autopsy? No

What test confirmed diagnosis? P. S. & Operation.

(Signed) John V. Segebrecht, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion	Dec 17 1923
20 UNDERTAKER Jas A. Dennis	ADDRESS 317 Fulton.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other known

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81790

CERTIFICATE OF DEATH.

44 D 81790

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Augusta Tews

(a) RESIDENCE No. 19 N. Elwood Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Tews

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert Tews

(Address) 19 N. Elwood Ave.

15 DEC 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1923, to Dec. 14, 1923, that I last saw her alive on Dec. 14, 1923, and that death occurred, on the date stated above, at 9.20 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall-bladder

(duration) 2 yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug. 15, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry U. P. Wilson Jr., M. D.

12-15-23 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Dec 17 1923

20 UNDERTAKER Ralph L. Cook ADDRESS 1003 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—5-19-13—M. & T.—500 Bks.

D 81791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 81791

REGISTERED No. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Md Gen'l Hospital St. 9 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Keating Jr

(Residence in Baltimore: No. 507 N. Patterson Park Ave St.; 1yr. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH, July 13, 1921
(Month) (Day) (Year)

7-AGE, 2 yrs. 5 mos. 1 ds.
If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Wm. E. Keating

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER, Florence E Counselman

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie E. Keating

(Address) 245 Wilkens Ave

DEC 17 1923 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec-14-, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-12- 1923, to 12-14- 1923, that I saw h[illegible] alive on 12-14- 1923, and that death occurred, on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH was as follows:*

Septic Peritonitis
Ruptured Appendicitis

(Duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary) Operation Shock Pneumonia

(Duration) 2 yrs. mos. ds.

(Signed) H. Stanley Gorsuch M. D.

12-15- 1923 (Address) 9910 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Dec. 17, 1923

20-UNDERTAKER Geo. L. Cook ADDRESS 1003 N. Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PERMIT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81792

CERTIFICATE OF DEATH.

D 81792

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 S. Stricker Street St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Edward McCormick

(a) Residence No..... 13 S. Stricker Street St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Delia McCormick.

6-DATE OF BIRTH (month, day and year): Oct. 15, 1856

7-AGE: 65 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Wood Worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Culpepper County Virginia

PARENTS.

10-NAME OF FATHER: James McCormick

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Alice Ryan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Katherine McCormick

(Address): 13 S. Stricker St.

15-

Filed....., 19.. ROBERT R. KRAUSE Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1923, to Dec. 14, 1923, that I last saw him alive on Dec. 14, 1923, and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirms diagnosis? Clinical Symptoms

(Signed) Edgar E. Powers, M. D.

12-15 1923 (Address) 1520 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec. 17, 1923
20-UNDERTAKER	ADDRESS
Joseph P. Cook	1003 N. Bond St.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81793

CERTIFICATE OF DEATH.

75-001 D 81793

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

2-FULL NAME Joseph Stanley

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Jan 3 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 7 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 20, 1917, to December 13, 1923.

that I last saw him alive on December 13, 1923,

and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Renal Hemiplegia (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude T. Lemon, M. D.

12-14-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery

DATE OF BURIAL 12/17 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1351 Hanford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81794

100-001 D 81794

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 956 Harford Ave ST., 10 WARD)

2-FULL NAME Domenico Darone

(a) RESIDENCE NO. 956 Harford Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Darone

6 DATE OF BIRTH (month, day, and year): Dec 20 1852

7 AGE: Years 70; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Pietro Darone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Frank Darone

(Address) 956 Harford Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 17 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13, 1923

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Dec 13, 1923

that I last saw him alive on Dec 13, 1923

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

17 Broncho Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DeStefano M. D.

Dec 15, 1923 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 12/17 1923

20 UNDERTAKER: George F. Ruth 1735

ADDRESS: Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81795

D 81795

CERTIFICATE OF DEATH.

X 101-60

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Delaware Hospital

CITY OF BALTIMORE: (No. Monument & Eutaw ST., 7 WARD)

2-FULL NAME John Skarotinsk

(a) RESIDENCE No. 248 Clyde Ave - Sandstown, WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: .....

6 DATE OF BIRTH (month, day, and year): Feb 20 1921

7 AGE: Years 2 | Months 10 | Days | If LESS than 1 day, ... hrs. or ..... in.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Anthony Skarotinsk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Londa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Anthony Skarotinsk

(Address): Clyde Ave Sandstown

DEC 7 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1923, to Dec 15, 1923, that I last saw him alive on Dec 15, 1923, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Sepsis

Pericarditis - purulent

(duration) ..... yrs. 1½ mos ..... ds.

CONTRIBUTORY (Secondary)

Empyema (duration) 1 yrs. 10 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 13 1923

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Ralph A. Weber, M. D.

, 19 (Address) Delaware Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 18 1923

20 UNDERTAKER: Enoch Brock Son — ADDRESS: 1911 Eastern Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81796

81796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1611 Barnes (St.) 7 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rich

(a) RESIDENCE. (No.) 1611 Barnes (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Rich

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamboat Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Rich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Anna Rich (Address) 1611 Barnes St

15 Filed ....., 19.... Registrar

DEC 17 1923 ROBERT R. KRAMER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1923 to Dec 13 1923

that I last saw h.... alive on Dec 12 1923

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculosis Laryngitis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Davis M. D.

12/16, 1923 (Address) 1500 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 17 1923
20 UNDERTAKER	ADDRESS
Enoch Gordon	1906 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81797

CERTIFICATE OF DEATH.

90 D 81797

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Collins

(a) RESIDENCE NO. 1138 E. Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 DEC 17 1923 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1923

17

I HEREBY CERTIFY, That I attended deceased from December 4 1923 to December 13 1923, that I last saw her alive on December 12, 1923, and that death occurred, on the date stated above, at 1:25 A.M.

The CAUSE OF DEATH* was as follows:

Obesity

Hypertension

Chronic Myocarditis (Degenerative)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1½ mos. (History)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Dixon, M. D.

12-13-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-17 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Penna Ave

Cor.—1-12-23—M&T—100 Bks.

D 81798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D 81798

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 Wilmer alley ST., 17 WARD)

2-FULL NAME Elizabeth Crowley

(a) RESIDENCE NO. 1139 Wilmer alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓		8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Leon Crowley

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Madeline Hawkins

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Leon Crowley
(Address) 1139 Wilmer alley

15 Filed DEC 7 1923 192 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 14 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. ..... mos. 2 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 16 1923 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL—CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-17 1923
20 UNDERTAKER Daniel Gorton	ADDRESS 376 E Lan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

162465 D 81799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 81799

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Martin Carter

(a) RESIDENCE NO. 630 N. Bruce ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	6			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Irene Hawkins

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1923 to Dec 14, 1923, that I last saw her alive on Dec 14, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute rheumatic fever - 1 yr.
Rheumatic endocarditis (mitral insufficiency) and myocarditis - 1 yr.
(duration) yrs. mos da.

CONTRIBUTORY (Secondary) X
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? X

(Signed) H. H. Wreath, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lavington Md — DATE OF BURIAL 12-17 1923

20 UNDERTAKER David Easter — ADDRESS 910 Penna Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 81800

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 Jefferson street St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Katzoff

(a) Residence No. 1725 Jefferson Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Meyer Katzoff

6-DATE OF BIRTH (month, day and year)

7-AGE. 67 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Josef Filipowitch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Fanny —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Baltimore St

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

DEC 17 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-16-23

17- I HEREBY CERTIFY, That I attended deceased from Sept 7, 1923 to Dec 16, 1923

that I last saw h[illegible] alive on Dec 15, 1923

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Metastatic from

Carcinoma of Stomach

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

Dec 17 1923 (Address) 222 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Kehreh Rosedale — DATE OF BURIAL. 12-17 1923

20-UNDERTAKER. Jack Lewis — ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81801

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Wallace

(a) RESIDENCE NO. Gamble's Mill Rd. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Uncertain yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Wallace

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 21

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond, Va
(State or country)

PARENTS

10 NAME OF FATHER Spencer Lane

11 BIRTHPLACE OF FATHER (city or town) Richmond, Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Beony

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant ..... (Address) Records.

15 Filed DEC 17 1923 ROBERT R. KRAUTER, Registrar
Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1923, to Dec. 16, 1923, that I last saw h[illegible] alive on Dec. 15, 1923, and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.
Chr. Hypertension.
Luetic endarteritis
Chr. nephritis (duration) Uncertain yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Arteriosclerosis (duration) Uncertain yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Inspection. Wassermann.

(Signed) David R. Nevitt M. D.

Dec 17, 1923 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill C. A. Cotton — DATE OF BURIAL Dec 18 1923

20 UNDERTAKER Sam'l W. Chase Son — ADDRESS 1600 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 81802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 168 Dolphin St., St. 11 Ward)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Brown

(a) RESIDENCE NO. 168 Dolphin St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dr. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Robt. Elliott
(Address) Dolphin & Mt. Dunmore

15 Filed DEC 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute parenchymatous nephritis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Dec. 16, 1923 (Address) 2812 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Med Cathedral Cem. — DATE OF BURIAL Dec. 17 1923

20 UNDERTAKER Mrs R. A. Elliott — ADDRESS 1721 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81803 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81803

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore, Md. 15

CITY OF BALTIMORE: (No. 3712 Forest Park Ave. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Dunlap Allen

(a) RESIDENCE. No. 3712 Forest Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
(or) WIFE of Walter Allen

6 DATE OF BIRTH (month, day, and year) Sept - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russellville, Ohio.

PARENTS

10 NAME OF FATHER Rev. James Dunlap

11 BIRTHPLACE OF FATHER (city or town) (State or country) Red Oak, Ohio.

12 MAIDEN NAME OF MOTHER Marguerite Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bloomsburg Ohio.

14 Informant Miss Alice Dunlap
(Address) 3712 Forest Park Ave.

15 Filed DEC 11 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923, to Dec. 16th, 1923, that I last saw her alive on Dec. 16th, 1923, and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart.

(duration) — yrs. — mos. Sudden ds.

CONTRIBUTORY (Secondary) Myocarditis & Arterio-Sclerosis (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination.

(Signed) Fred A. Clark, M. D.

, 19 (Address) 3327 Forest Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield Ohio	Dec 17 1923
20 UNDERTAKER George J. Smith	ADDRESS 1532 Pleasant

Spec—12-23-21—E.B.R.S.—400 Bks.

(Derechinger)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81804

D 81804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1342 Fawson St., 24 Ward) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Derechinger

(a) Residence No. 1342 Fawson St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Derechinger

6-DATE OF BIRTH (month, day and year) March 8, 1855

7-AGE. 68 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Martin Derechinger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Carrie A Kaper

(Address) 1342 Fawson St

15- Filed DEC 17 1923 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 15. 1923

17- I HEREBY CERTIFY, That I attended deceased from November 15 1923 to December 15 1923

that I last saw him alive on December 15 1923

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis Sclerosis Rheumatism 20 years

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos La Stevens, M. D

Dec 16, 1923 (Address) 2818 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Dec. 18 1923

20-UNDERTAKER. Chas. L. Stevens — ADDRESS 1501 Pontiac

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Blks.

81805

Swan

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 81805

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Chadford Apts.

CITY OF BALTIMORE: (No.) University Parkway ST. 27 (WARD)

2-FULL NAME Isabel Alexander Swan

(a) RESIDENCE No. Chadford Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	Sixty four	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Swan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabel Deries

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Howard C Lloyd (Address) Tudor Hall

15 DEC 17 1923 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ Dec 16th, 1923, to Dec. 15th, 1923, that I last saw her alive on Dec. 14th, 1923, and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis / Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. Chatard, M. D.

Dec 16, 1923 (Address) 40 W. Biddle St.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul's Cem — DATE OF BURIAL Dec 17 1923

20 UNDERTAKER Henry H Jenkins Sons Co — ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 81806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D 81806

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Hanover ST., 23 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Anne Hooper

(a) RESIDENCE NO. 1005 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 28/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER William Hooper

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Esther Gaughan

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Mr William Hooper
(Address) 1005 Hanover St

15 Filed DEC 17 1923 ROBERT B. KNAUER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1923, to Dec 15, 1923, that I last saw h[illegible] alive on Dec 15, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Probably intestinal Dis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hubert Draper, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 17 1923
20 UNDERTAKER	ADDRESS
James Dignan's Son	1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 81807

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 81807

REGISTERED No. C 21 154-002

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4705½ Reisterstown Rd St. ..... WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Ford

(Residence in Baltimore: No. 4705½ Reisterstown Rd St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
F	W	White

6-DATE OF BIRTH Dec 14, 1923
(Month) (Day) (Year)

7-AGE X yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE (State or country) Baltimore, Md

PARENTS

10-NAME OF FATHER Elmer Ford

11-BIRTHPLACE OF FATHER (State or country) Baltimore Co

12-MAIDEN NAME OF MOTHER Pearl Mae Cherry

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Ford

(Address) 4705 Reisterstown Rd

15-

Filed DEC 17 1923 191 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Dec 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec 15 1923

that I saw h[illegible] alive on Dec 15, 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pertussis Broncho Pneumonia

36 hours
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maurice R. Davis M. D.

Dec 15, 1923 (Address) 706 N. Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woods Chapel Cemetery	Dec 18, 1923

20-UNDERTAKER Josiah Oppenheimer ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81808

CERTIFICATE OF DEATH.

31 D 81808

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Pennsylvania Ave WARD) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Scribner

(a) RESIDENCE NO. 939 Pennsylvania Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced (or) WIFE of Ernest W. Scribner

6 DATE OF BIRTH (month, day, and year) Dec, 15, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westmoreland
(State or country) Virginia

PARENTS

10 NAME OF FATHER Stanley Smith

11 BIRTHPLACE OF FATHER (city or town) St Marys Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Smith

13 BIRTHPLACE OF MOTHER (city or town) Westmoreland
(State or country) Virginia

14 Informant Henrietta Smith
(Address) 835 Boyd St

15 Filed ..... 19 ..... Burial Permit ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec, 12, 1923, to Dec, 13, 1923, that I last saw h[illegible] alive on Dec, 13, 1923, and that death occurred, on the date stated above, at 7.15 a/m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? None.

(Signed) Wm J Faucher M. D.

12/15/1923 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Clutrum Cem	12/17/23
20 UNDERTAKER Samuel H Kemler	ADDRESS 578 N Bdle

DEC 17 1923

ROBERT N. KRAUTER

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81809 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 81809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 23 47 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Martin

(a) Residence No. 1129 Race St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimre, Md.

PARENTS.

10-NAME OF FATHER, Henry Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Sarah Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- Municipal Hospital Records (Informant)

(Address)

15- Filed DEC 17 1923 ROBERT R. [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from December 7 1923 to December 12 1923

that I last saw her alive on December 12 1923

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

with generalized metastasis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. L. Sutton M. D

12-12-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Lebanon Cem	12-17-23
20-UNDERTAKER, Samuel Wheatley	ADDRESS 1775 Mc Elderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81810

CERTIFICATE OF DEATH.

161-001

D 81810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Jenkins Al. ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Scroggins

(a) RESIDENCE NO. 1120 Jenkins al ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/11/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Scroggins

11 BIRTHPLACE OF FATHER (city or town) Charles Co. Md (State or country)

12 MAIDEN NAME OF MOTHER Barbara Johnson

13 BIRTHPLACE OF MOTHER (city or town) Charles Co. Md (State or country)

14 Informant Mother Barbara Scroggins (Address) 1120 Jenkins al.

15 FILED DEC 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/12 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/11, 1923, to 12/12, 1923, that I last saw h[illegible] alive on 12/11, 1923, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Otto Reen M. D.

12/13 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem

DATE OF BURIAL 12/17 1923

20 UNDERTAKER Samuel Weasley Boyle

ADDRESS 778

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Dr Riley Female Wounding

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81811

CERTIFICATE OF DEATH.

D 81811

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 1 WARD)

2-FULL NAME John M. Sapp

(a) RESIDENCE No. 2114 Cambridge ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cherie E. Sapp

6 DATE OF BIRTH (month, day, and year) Mar 14 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H Sapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliza Weibley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Cherie Sapp
(Address) 2114 Cambridge St

15 Filed DEC 7 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

Chronic (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Salmon Edema

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T Riley, M. D.
(Coroner.)

Dec 16 1923 (Address) 165 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) In the
At place of death ..... yrs., ... mos., ... ds. State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Dec 19 1923

20 UNDERTAKER Wm Cook — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81812

CERTIFICATE OF DEATH.

D 81812

X 197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 216 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanley K. Mitchell Jr.

(a) RESIDENCE No Solley's A. A. Co. Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 9, 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Stanley K. Mitchell Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Minnie Stockman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Stanley K. Mitchell Sr. (father)
(Address) Solley's A. A. Co Md

15 Filed DEC 17 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy and inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis due to a pistol shot wound in the abdomen.

Homicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Dec, 16, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Snow Hill, Curtis Bay, C. C. Co. Md.

Former or usual residence Dec, 13, 1923.

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Presbyterian Govans — DATE OF BURIAL 12/17 192 3

20 UNDERTAKER Wm Cook — ADDRESS 502 E Lex

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 S. Highland Ave. Ward 16)

REGISTERED No. 179 D 81813

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hager

(a) RESIDENCE No. 21 S. Highland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of late Nicholas Hager

6 DATE OF BIRTH (month, day, and year) Oct 25/44

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Kissling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Stewart

(Address) 21 S. Highland Ave

15 Filed DEC 1 7 1923 ROBERT R. KRAMER Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 1923, to Dec 15 1923, that I last saw her alive on Dec 15 1923 and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Chr. Interstitial

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dwight S. Sadler, M. D.

Dec 16 1923 (Address) 1336 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mathews | DATE OF BURIAL Dec 18 1923

20 UNDERTAKER Philip Herwig | ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81814

CERTIFICATE OF DEATH.

89 D 81814

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S 5th ST., 16 WARD)

2-FULL NAME Alexander G. Ballantine

(a) RESIDENCE NO. 105 S 5th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Saunders

6 DATE OF BIRTH (month, day, and year) Dec 3-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 16

(b) General nature of industry, business, or establishment in which employed (or employer) Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alexander Ballantine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Clara Ballantine

(Address) 105 S 5th St

15 Filed DEC 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1919, to Dec 16, 1923, that I last saw him alive on Dec 16, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart Arteries Heart Condition

(Signed) D T Mathe M. D.

, 19 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Dec 19 1923

20 UNDERTAKER John Ullrich — ADDRESS 2 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81815

CERTIFICATE OF DEATH.

162 D 81815

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 862 St Peter St ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Catherine Wilbur

(a) RESIDENCE NO. 862 St Peter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Wilbur

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nebbin Marsten

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Father

(Address)

15 Filed DEC 7 1923 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1923, to Dec 16, 1923, that I last saw h[illegible] alive on Dec 15, 1923, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hilborn Neer, M. D.

12/7/1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec 17 1923
20 UNDERTAKER	ADDRESS
Knell & Son	1127 W Pratt st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 31816

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 188-093 31816

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Ag Hospital ST., 27 WARD)

2-FULL NAME Harry Davies

(a) RESIDENCE NO. 825 Light ST., ... WARD Phila Pa
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May Davies

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 666
(c) Name of employer

9 BIRTHPLACE (city or town) Oregon
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant May Davies (wife)
(Address) 825 Light St

15 Filed DEC 17 1923, 192 ..... ROBERT R. KRAUT Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Died death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures Legs, Accident

(duration) ..... yrs. ..... mos. Instt. hrs.

CONTRIBUTORY (Secondary) Shock.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clifford Shanks, M. D.
(Coroner.)

Dec 15 1923, 192 (Address) 1426 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila. Pa Penn R.R.

DATE OF BURIAL Dec 18 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of Mor-
CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state
TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81817

CERTIFICATE OF DEATH.

118-89 D 81817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Armsworthy

(a) RESIDENCE NO. 539 W. Conway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Cooper 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Armsworthy

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Addie E. Barnes

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital Records.

(Address)

15 DEC 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/15/23

17

I HEREBY CERTIFY, That I attended deceased from 12/11/23, 19..., to 12/15/23, 19..., that I last saw h— alive on 12/15/23, 19..., and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) Tapeworm

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 11/13/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Operation

(Signed) H. W. Goelet, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	12/18 1923
20 UNDERTAKER	ADDRESS
George & Ruth	1730 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Eilts

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81818

CERTIFICATE OF DEATH.

46 D 81818

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary Eilts

(a) Residence No.... 1729 E. Lombard St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Eilts

6-DATE OF BIRTH (month, day and year) 5/19 1898

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James Milka

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14- (Informant) James Milka

(Address) 1729 E. Lombard St.

15- 507 N. Patterson Park Ave.

Filed..... 192.....

DEC 17 1923 ROBERT R. KANE Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/15/23.

17- I HEREBY CERTIFY, That I attended deceased from Aug 26 1923 to Dec. 15 1923 that I last saw h.. alive on Dec 15 1923, and that death occurred, on the date stated above, at 11-15 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix
- Secondary to pelvic glands.

(Duration) yrs 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Eilts M. D

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Dec 18 1923

20-UNDERTAKER, George J. Ruth ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form.—6-9-19—H. P. Co.—1000 Bks.

D 81819 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81819

CERTIFICATE OF DEATH. 15 - X902

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3806 Dorchester Road ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A.Frank,

(a) RESIDENCE. No. Lock Haven Pa. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ (HUSBAND) of (or) WIFE of John H.Frank,

6 DATE OF BIRTH (month, day, and year) July 4. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jersey Shore .Penna.

PARENTS

10 NAME OF FATHER Phillip Anthony,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Philobena Basehar,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sister in Law

(Address) 3806 Dorchester Road

15 Filed DEC 17 1923 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.16.1923 19

17 I HEREBY CERTIFY, That I attended deceased from 11-10, 1923, to 12-16, 1923.

that I last saw her alive on 12-16, 1923.

and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac - insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility - Cardio Renal disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter T Hampson, M. D.

12/17/1923 (Address) 2806 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lock Haven Pa.	Dec.18.1923

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

Spec.—1-10-21—M&T—1500 Blks.

Buck.

D 81820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D 81820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Buck.

(a) RESIDENCE No. 506 N. Rose St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 845

(b) General nature of industry, business, or establishment in which employed (or employer) Hucksters

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Wm. Buck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Starkey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records.

(Address)

15 DEC 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/23

17

I HEREBY CERTIFY, That I attended deceased from 12/10/23, to 12/14/23, that I last saw him alive on 12/14/23, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

(Lumbar Potts Disease)

Osteo Arthritis Lumbar Spine

?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyemia - Cystitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) K. M. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 12-17 1923

20 UNDERTAKER J. G. Moran

ADDRESS 3000 E Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

TYPE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81821

CERTIFICATE OF DEATH.

44 D 81821

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 Bank st. ST., 7 WARD)

2-FULL NAME Alice Lindemann

(a) RESIDENCE No. 2036 Bank St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 14.1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	45	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Matyland

PARENTS

10 NAME OF FATHER John Lindemann

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hammann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France

14 Informant John Lindemann
(Address) 2036 Bank St.

15 Filed DEC 17 1923 ROBERT R. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.15.1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Dec 15, 1923, that I last saw h[er] alive on Dec 14, 1923, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Leo. J. Keller, M. D.

Dec 15, 1923 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	12/17/23
20 UNDERTAKER	ADDRESS
Milton W. Jones	424 N. Broadway

BALTIMORE

Spec.—1-10-21—M&T—1500 Blks.

D 81822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 81822

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST., 18 WARD)

2-FULL NAME John L Jones

(a) RESIDENCE NO. 111 Carrollton Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 18, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stonecutter

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Jones

11 BIRTHPLACE OF FATHER (city or town) Baltr (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Dixon

13 BIRTHPLACE OF MOTHER (city or town) Baltr (State or country) Md.

14 Informant Mrs Kaufman

(Address) 1207 W Lexington St

15 Filed DEC 17 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to Dec 17, 1923, that I last saw him alive on Dec 17, 1923, and that death occurred, on the date stated above, at 12:35 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema - cachexia - carcinoma of prostate - metastasis rt. femur (duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. Alexander Mowery M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Com DATE OF BURIAL Dec 19 23

20 UNDERTAKER Ger. H. Fuhs ADDRESS 2100 Edmondson Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 31823

D 31823

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 Ashland Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George. H. Steer

(a) RESIDENCE NO. 2106 Ashland Ave ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Annie M. Steer.

6 DATE OF BIRTH (month, day, and year) Sept. 15 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer on dock

(b) General nature of industry, business or establishment in which employed (or employer): Mr. Clair, ship

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Francis Steer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rachal Dorsey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D C

14 Informant: Mrs. Annie M. Steer.

(Address) 2106 Ashland Ave

15 Filed DEC 17 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec. 17, 1923, that I last saw him alive on Dec 16, 1923, and that death occurred, on the date stated above, at 5.15 a m.

The CAUSE OF DEATH* was as follows:

(Primary) Myocardial degeneration

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Probably cerebral or pulmonary embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Joseph Pokorny, M. D.

19 (Address) 2124 Ashland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 19 23
20 UNDERTAKER	ADDRESS
Henry Hoech Son	1201 E Eager st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81824

90 D 81824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 N. Central ave ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. August. Albrecht

(a) RESIDENCE NO. 1220 N. Central Av ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rosina Albrecht.

6 DATE OF BIRTH (month, day, and year) February 28 1842

7 AGE — Years: 80 — Months: 9 — Days: 17 — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Paver

(b) General nature of industry, business, or establishment in which employed (or employer): 077

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Andrew Albrecht.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Mary Sohner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Mrs Rosina Albrecht

(Address) 1220 N. Central ave

Filed DEC 7 1923, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1923 to Dec. 15, 1923, that I last saw him alive on Dec 14, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) .....

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob Fisher, M. D.

12/16 1923 (Address) 1823 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemtry — DATE OF BURIAL: Dec. 18 1923

20 UNDERTAKER: Henry Hordt & Son — ADDRESS: 1410 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

Dr Hennessey – Edmondson Av

D 81825

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 81825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Md General Hosp. ST., 22 WARD)

2-FULL NAME Matilda Miller

(a) RESIDENCE NO. 200 E. Church ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Miller

6 DATE OF BIRTH (month, day, and year) Nov. 28/845.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Odell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Emma Jean Hanson.
(Address) 140 Madison Ave.

15 Filed DEC 17 1923, 192. E. HATTISON, Registrar

Burial Permit Clerk

C/o Leon Miller – Via P.R.R.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Sr. humerus (accidental fall down stairs)

in Leon home (duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Dec. 16, 1923 (Address) 280 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Williamsport Pa.	Dec 18 1923

20 UNDERTAKER ..... ADDRESS .....

Wm. Cook. 502 E. Fayette

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be stated EXACTLY. PHYSICIAN'S ... AGE should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81826

CERTIFICATE OF DEATH. X 58-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 7

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No..... ST., ... WARD)

2-FULL NAME Mary J. C. Bender

(a) RESIDENCE No. Martinsburg W. Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 70 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lee Bender

6 DATE OF BIRTH (month, day, and year) — 1861

7 AGE: 63 Years | — Months | — Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Armenius S. Hank
11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.
12 MAIDEN NAME OF MOTHER Mary Vandiver
13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... 1923 ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23 - 1923, to Dec 16 - 1923, that I last saw her alive on Dec 16 - 1923, and that death occurred, on the date stated above, at 1250 noon

The CAUSE OF DEATH* was as follows:
Pernicious Anaemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Contused Scalp Ford

(duration) ... yrs. 7 mos. ... ds.

18 Where was disease contracted if not at place of death? Martinsburg W. Va

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Blood examination

(Signed) Trevor Owen, M. D.

Dec 16 1923 (Address) Johns Hopkins Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chambersburg Pa. | DATE OF BURIAL: Dec. 1923

20 UNDERTAKER: John C. Mitchell | ADDRESS: 1201 W. Fayette St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81827

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 81827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1514 Harlem ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Milton Benson

(a) Residence No. 1514 Harlem Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah V. Canter

6-DATE OF BIRTH (month, day and year) Dec 13. 1844

7-AGE. 79 yrs. — mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... farmer

(c) Name of employer..... a. a. Co. Md.

9-BIRTHPLACE (city or town)..... (State or Country),

PARENTS.

10-NAME OF FATHER, Basil S. Benson

11-BIRTHPLACE OF FATHER (city or town)..... a. a. Co (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Ann Smith

13-BIRTHPLACE OF MOTHER (city or town)..... a. a. Co (State or Country), Md.

14- (Informant) Sarah V. Benson

(Address) 1514 Harlem ave

15- DEC 17 1923 1923 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 15. 1923

17- I HEREBY CERTIFY, That I attended deceased from May 15th 1923 to Dec 15th 1923, that I last saw him alive on Dec 15th 1923, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(Duration) 3 weeks yrs. mos. ds.

18-Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. F. Hill M. D.

19 (Address) 1208 Madison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Shipley's a. a. Co. | DATE OF BURIAL, Dec 18 1923

20-UNDERTAKER, John O. Ditchue | ADDRESS 1209 W. Fayette St.

DEC 17 1923

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1643 81828

100 D 81828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.....) ST., 7 WARD)

2-FULL NAME Irwin J. Harrison

(a) RESIDENCE NO. 513 N. Bond St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jas. Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Gertrude Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 17 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15-1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 5-, 1923, to Dec 15-, 1923, that I last saw him alive on Dec 15-, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia — 12 da.

Empyema — 3 da.

Pneumococcus meningitis — 1 d.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. H. Weech, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec. 18 1923
20 UNDERTAKER	ADDRESS
Wm. J. Locke	1302 Jefferson

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

July 11/12 # 32062

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Date of Birth - corrected by the advice of Dr. Weech

Moore.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81829

CERTIFICATE OF DEATH.

90 D 81829

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1100 Myrtle Ave ST., 17 WARD)

2-FULL NAME Sarah L. Elder

(a) RESIDENCE No. 1100 Myrtle Ave ST., 17 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE Colored
5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, ~~or divorced~~ (or) WIFE of Daniel Elder

6 DATE OF BIRTH (month, day, and year) Unk. 1868

7 AGE Years ✓✓ Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS
10 NAME OF FATHER John Parks
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Frances Parks
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant N. Melton Frost
(Address) 1100 Myrtle Ave.

15 Filed DEC 7 1923, 19 Robert F. Mattson, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922, to Dec 16, 1923, that I last saw h[illegible] alive on Dec 7, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis
(duration) yrs. 10 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dow Hemmeter, M. D.
Dec 17 1923 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem
DATE OF BURIAL 12/18 1923

20 UNDERTAKER Daniel J Hensley
ADDRESS 738 W Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81830

CERTIFICATE OF DEATH.

129 D 81830

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 555 Gruenwillow ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Moore

(a) RESIDENCE No. 555 Gruenwillow ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20-8[illegible]

7 AGE: Years 39 Months 8 Days 22 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9 BIRTHPLACE (city or town) Royal Oak
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Fields

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country) [illegible]

14 Informant [illegible]
(Address) [illegible]

15 Filed DEC 17 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16— 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 16— 1923, to Dec 16— 1923,
that I last saw her alive on 12/16— 1923,
and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Nephritis
(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. A. Davidson, M. D.

(Address) 340 N Chester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Royal Oak Md — DATE OF BURIAL: 12/18 1923

20 UNDERTAKER: Edward L Stanley — ADDRESS 178 N Bond

DEC 17 1923

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

William Johnson Jr ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE 3D 31831

D 31831

CERTIFICATE OF DEATH.

188-00

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 18 WARD)

2-FULL NAME Mrs Johnson

(a) RESIDENCE No. 833 N. Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plaster
(b) General nature of industry, business, or establishment in which employed (or employer) 057
(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg Va
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Lula Garrett
(Address) 833 N Franklin St

15 Filed DEC 17 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, autopsy or inquiry.~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

a few hours
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) struck by automobile
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Jones, M. D.
(Coroner.)

12-15, 1923 (Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 12/18 1923

20 UNDERTAKER Samuel J Hemsley

ADDRESS 1738 Druid

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 1423 W. Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Knapp (Knapp)

(a) Residence No. 1423 W. Lanvale St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary M. Knapp

6-DATE OF BIRTH (month, day and year): 18 April 1847

7-AGE: 76 yrs. 7 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer Plater

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS:

10-NAME OF FATHER: Peter Knapp

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Thompson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-(Informant) Mrs. Mary M Knapp
(Address) 1423 W. Lanvale St.

15-Filed DEC 17 1923 192 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 15, 1920 to Dec 16, 1923, that I last saw h. alive on Dec 16, 1923, and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Edward A Morgan M. D.

12-17-23 (Address) 1322 Hanlon ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dallas Mount Cem	Dec 19, 1923
20-UNDERTAKER	**ADDRESS**
Jos L. Cook	1003 W. Baltimore St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81833

16800 2

CERTIFICATE OF DEATH.

X 131 D 81833

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Charles Read

(a) RESIDENCE No. 6 Eden Ter. Catonsville ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Read

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Read

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 17 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 27th, 1923, to Dec 16th, 1923,

that I last saw h[illegible] alive on Dec 16th, 1923,

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? England

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Trevor Owen, M.D.

Dec 16 1923 (Address) Johns Hopkins Hospital Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 19 1923
20 UNDERTAKER	ADDRESS
Joseph L. Cook	1013 N Gilts St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81834

CERTIFICATE OF DEATH.

168 D 81834

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 505 Brune St. ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt. Monroe

(a) RESIDENCE NO. 505 Brune St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rena Monroe

6 DATE OF BIRTH (month, day, and year) about 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General) 40 yrs
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robt. F. Monroe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rena Monroe
(Address) 505 Brune St.

Filed ..... 192 .....

EC 1 71923

Robert F. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an enquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Laudanum (Road)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec. 17, 1923 (Address) 208 Courthouse

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 18 1923
20 UNDERTAKER	ADDRESS
Thos Gent Hooper	406 W. Conway St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81835

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 81835

01-001 [illegible] 0

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 765 W Saratoga ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Butler

(a) RESIDENCE NO. 765 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Negro | 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed or divorced HUSBAND of (or WIFE of) Adeline Butler

6 DATE OF BIRTH (month, day, and year) 3-1st 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster packer

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster house 06

(c) Name of employer Wm Jacobs & Sons

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER Emma Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Robt Butler (Address) mother

15 Filed DEC 18 1923, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-15 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/2, 1923, to 12/15, 1923, that I last saw h[illegible] alive on 12/14, 1923 and that death occurred, on the date stated above, at 10:50 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Jackson M. D.

12/17 1923 (Address) 808 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 12-18 1923

20 UNDERTAKER Daniel Easton — ADDRESS 911 Ba ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81836 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81836

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Ford

(a) RESIDENCE No. 806 Parish st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md
(State or country)

PARENTS

10 NAME OF FATHER John Ford

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Mason

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John Ford
(Address) 806 Parish St

15 Filed DEC 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(duration) yrs. About Three mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W K Fowler, M. D.
(Coroner.)

12-17, 1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 12-18 1923

20 UNDERTAKER David Easton — ADDRESS 716 Cathedral

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information is required by law. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state AGE TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81837

CERTIFICATE OF DEATH.

31 D 81837

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Louisa Hinton

(a) RESIDENCE No. 1426 McElderry St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Hinton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 16 1923, 19 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 —, 1923, to Dec 16 —, 1923, that I last saw h— alive on Dec 16 —, 1923, and that death occurred, on the date stated above, at 6-00 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(cause undetermined)

? (duration) probably yrs. few mos (?) ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Warfield M. Firor, M. D.

12/16, 1923 (Address) 6th Floor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemty	Dec 20 1923
20 UNDERTAKER	ADDRESS
Mrs M. G. Elliott	Eastland Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81838

CERTIFICATE OF DEATH.

101.00

D 81838

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 W. Cullodh St., 14 WARD)

2-FULL NAME William Briggs

(a) RESIDENCE No. 1924 W. Cullodh St., ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Briggs

6 DATE OF BIRTH (month, day, and year) about 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) (General)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Suffolk, Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Robt. Elliott
(Address) 1924 W. Cullodh St.

15 Filed DEC 18 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

EC 1 81923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

(Address) 100 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos , ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Penwood Cemetery Va. DATE OF BURIAL Dec 18 1923

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1924 W. Cullodh St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81839 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81839

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 24-001

City of BALTIMORE: (No. 2401 Frederick Av St., 19th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Adt

(a) Residence No. 2401 Frederick Av St., 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 2 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Frank Adt.

6-DATE OF BIRTH (month, day and year): Feb 15, 1851

7-AGE: 72 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Christian Hemmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mrs. H. Metzgel

(Address): 2401 Frederick Av

15- DEC 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 17/23

17- I HEREBY CERTIFY, That I attended deceased from Sept 30th 19.22 to Dec 17th 19.23

that I last saw h[illegible] alive on Dec 17th 19.23

and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Cerebral Embolism (Summer)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L Wessler M. D.

19 Office 2555 Frederick Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: Dec 19.23

20-UNDERTAKER: F. B. Keyser — ADDRESS: 2256 Frederick Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Haemorrhage.

Spec.—1-10-21—M&T—1500 Bks.

D 81840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81840

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Dorothy Toles

(a) RESIDENCE No 236 N. Durham St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20 1923

7 AGE: Years | Months 10½ | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Toles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Cora Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 12, 1923, to Dec 16, 1923, that I last saw her alive on Dec 16, 1923, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of Heart

(duration) Life yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? X Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) H. H. Weed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery | DATE OF BURIAL: Dec 19th 1923

20 UNDERTAKER: Milton Davis | ADDRESS: 315 N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81841 — 129 D 81841

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520-N-Arlington-Av. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM FORNERET JONES

(a) RESIDENCE NO. 520-N-Arlington-Av. ST., 18 WARD (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 73 yrs. 4 mos. 12 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Richardson Jones

6 DATE OF BIRTH (month, day, and year) Aug-4-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer): Printing

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Elkton, Cecil Co., Maryland

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co. Maryland

12 MAIDEN NAME OF MOTHER Mary Thawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cecil Co., Maryland.

14 Informant: Mrs. Emma R. Jones, (wife)
(Address) 520-N-Arlington-Av., City

15 Filed ..... 19 .. ROBERT R. KRAUTER, Registrar

DEC 18 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8th, 1923, to Dec 16th, 1923, that I last saw him alive on Dec. 15th, 1923 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Herbert F. Hellmann, M. D.

, 19 (Address) 6 E Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
DRUID RIDGE CEMETERY	DEC-18 1923
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS: 103 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. AGE mation should be stated EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81842 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81842

CERTIFICATE OF DEATH.

REGISTERED NO. 24-006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Cathedral ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Appold Wilson

(a) RESIDENCE NO. 1019 Cathedral ST., 11 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? 78 yrs. 3 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (now)

6 DATE OF BIRTH (month, day, and year) Aug-26-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Y. Wilson

11 BIRTHPLACE OF FATHER (city or town) Chester Co.
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Jane Appold

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Sam'l. Young Wilson - (Bro.)
(Address) 1019 Cathedral St

15 Filed DEC 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28th, 1923, to Dec. 16th, 1923, that I last saw him alive on Dec. 16th, 1923, and that death occurred, on the date stated above, at 8 o'clock P m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(duration) — yrs. — mos. 19 ds.

CONTRIBUTORY (Secondary) ——— (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thomas L. Shearer, M. D.

Dec. 17th, 1923 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Dec 19 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE... mation should be carefully supplied. AGE should be stated EXACTLY. E... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates. ... state of OCCUPA...

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81843

CERTIFICATE OF DEATH.

D 81843

93

1-PLACE OF DEATH Baltimore md

CITY OF BALTIMORE: (No. 3823 Ashburton Ave ST.) 15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wilhelm

(a) RESIDENCE. No. 3823 Ashburton Ave, WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis R. Wilhelm

6 DATE OF BIRTH (month, day, and year): 6-2-1856

7 AGE — Years: 67 — Months: 7 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Graf.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mot Rinehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mary A Wilhelm
(Address) 3823 Ashburton ave

15 DEC 18 1923 ROBERT S. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1923 to Dec. 16, 1923

that I last saw her alive on Dec. 14, 1923

and that death occurred, on the date stated above, at 4:00 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism causing practically instantaneous death and due to (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Phlebitis (of L. saphenous V.) (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? over

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Barnes C. Baggott, M. D.

, 19 (Address) 1015 Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 12-19 1923

20 UNDERTAKER: Mrs Chas G. Robb & Co — ADDRESS: Mardingsville

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N Calhoun St., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wm Houck

(a) RESIDENCE NO. 702 N Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Houck

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years 60 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Keeper 040

(b) General nature of industry, business, or establishment in which employed (or employer) Bottling Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Shultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Catherine Houck (Address) 702 N Calhoun St

15 Filed DEC 18 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1923, to Dec. 15, 1923.

that I last saw h alive on Dec. 16, 1923

and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Metastasis to Liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Pancreatitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Loss of weight Fluid in abdomen

(Signed) Thos. H. Shultz, M. D.

, 19 (Address) 2301 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL 12/18 1923

20 UNDERTAKER Geo A Farley Fulton & Fayette — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Apson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/84845 16

CERTIFICATE OF DEATH.

113 D 81845

1-PLACE OF DEATH Johns Hopkins Hospital. V

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No..... ST., ... WARD)

2-FULL NAME Chester Apson

(a) RESIDENCE NO. 2027 Eden St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... " "

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Apson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dora Kanagoglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1923 to Dec 17, 1923

that I last saw him alive on Dec 17, 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Vomiting & diarrhoea (not dysentery)

..... (duration) yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) X

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) H. H. Wasch, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 18 1923
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 E. Lombard ST., V WARD)

2-FULL NAME Annie Kelly

(a) RESIDENCE No. 2015 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 3rd 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home ~~Girl~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath. Galahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Sarah Kelly (Address) 2015 E. Lombard St

15 Filed DEC 18 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Dec 15, 1923, that I last saw h[illegible] alive on Dec 15, 1923, and that death occurred, on the date stated above, at 8-35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

12-18, 1923 (Address) 120 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	12-19 1923
20 UNDERTAKER J. J. Moran	ADDRESS 300 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81847

REGISTERED NO. 15 2002 81847

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 612 E. 29th St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Lambdin

(a) RESIDENCE. No. 612 E. 29th St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 13, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. C. Lambdin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt. Md.

12 MAIDEN NAME OF MOTHER: Clarissa C. Bare

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt. Md.

14 Informant (Address): Wm. C. Lambdin 612 E. 29th St.

Filed DEC 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1923 to Dec. 16, 1923

that I last saw her alive on Dec. 16, 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac disease

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John L. Bruns, M. D.

1923 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	12-18 1923

20 UNDERTAKER: J. A. Moran

ADDRESS 3001 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81848

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Paynter.

(a) RESIDENCE No. 2043 E. Hoffman. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Paynter

6 DATE OF BIRTH (month, day, and year) June 25-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68.	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 080

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nathaniel W. Paynter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Dinsdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Alice E. Paynter

(Address) 2043 E. Hoffman St

15 Filed DEC 18 1923, ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Dec 17, 1923, that I last saw alive on Dec 17, 1923, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schenuit, M. D.

, 19 (Address) St. Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 12/18 1923

20 UNDERTAKER: Chas. F. Evans & Son — ADDRESS: 118 W. Mt. Royal Ave

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81849

CERTIFICATE OF DEATH.

74001 D 81849

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 S Bunny ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcin Pawlak

(a) RESIDENCE NO. 1013 S Bunny ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1867 Nov 15

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Pawlak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Pawlak

(Address) 1023 S Bunny St

15 Filed DEC 19 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec 16, 1923, that I last saw h[illegible] alive on Dec 16, 1923, and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry D. Shanthell, M. D.

, 19 (Address) 2372 Callow Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Dec 20 1923
20 UNDERTAKER	ADDRESS
Stephen J Kalkowski	1000 S Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 31850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31850

CERTIFICATE OF DEATH.

1 177

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Joseph Hospital ST.: 1 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Chychla

(Residence in Baltimore: No. 823 S. Linwood Ave St.; yrs., 25 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, July (Month) 15 (Day), 1889 (Year)

7-AGE, 50 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Bartholemie Apertowicz

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Juliana Kendzjewska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nestor Cidelo

(Address) 823 S. Linwood Ave

15- Filed ..... 191.....

ROBERT R. KRAUTER
Burial Permit Issued
Registrar.

DEC 18 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 16/23 (Day)., 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns & Oedema of throat-Chloride of lime swallowed, mistaken for Sodium Bicarb. in darkness.

..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

..... (Duration)..... yrs..... mos..... ds.

(Signed) J. L. Kolen M. D.
(Coroner.)

Dec. 17/23 (Address) 508 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	Dec 19, 1923
20-UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1000 S. Kenwood Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81851

CERTIFICATE OF DEATH.

100-001

100 D 81851

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie A. Banks

(a) RESIDENCE No. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced (HUSBAND of) (or) WIFE of John W. F. Banks

6 DATE OF BIRTH (month, day, and year) 2-4-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Municipal Hospital Records.

(Address)

DEC 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from November 19, 1923, to December 17, 1923, that I last saw her alive on December 16, 1923, and that death occurred, on the date stated above, at 5:25 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Charles G. Drum, M. D.

12-17-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Dec 19 23

20 UNDERTAKER Wm Cook

ADDRESS 502 E Mon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81852 HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 81852

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Elizabeth Phillips

(a) RESIDENCE No 1535 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Phillips

6 DATE OF BIRTH (month, day, and year) Oct 24/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick W. Rossel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant F. William Russel
(Address) 1532 E. Biddle St

15 Filed DEC 19 1923 192 ROBERT B. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental-clothing caught fire from gas heater in bed room. (Burns over greater portion of body & head) (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Owens, M. D. (Coroner.)

Dec 17 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Dec. 18 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E North

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KEEP CLEAN

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81853

CERTIFICATE OF DEATH.

161-001

D 81853

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 S. Decker Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ferenc

(a) Residence No. 1102 S. Decker Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 14-1923

7-AGE. — yrs. — mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Joseph F. Ferenc.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Gertrude McKenna

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Joseph F. Ferenc.
(Address) 1102 S. Decker Ave

15- DEC 18 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 18-1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1923 to Dec 18, 1923 that I last saw h[illegible] alive on Dec 17, 1923. and that death occurred, on the date stated above, at 2.30 A m. The CAUSE OF DEATH* was as follows:

Inanition

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth (6½ mos)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Kroger M. D

, 19 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus Cem.	Dec. 20, 1923
20-UNDERTAKER.	ADDRESS
Zickler & Zickler	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 81854

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 813 S. Potomac St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Smith Sr.

(a) Residence No. 813 S. Potomac St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie E. Smith

6-DATE OF BIRTH (month, day and year) Feb. 22 1851

7-AGE.	If LESS than 1 day.
72 yrs. 10 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not known

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), not known

14- (Informant) James A. Smith, Jr.

(Address) 813 S. Potomac St.

15- Filed ..... 192.....

ROBERT R. KRAUT

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 17-1922.

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1922, to Dec 17 1922

that I last saw h[illegible] alive on Dec 17, 1922

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Partial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTOR (Secondary) Cardiac Hypertrophy

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O. L. Fox, M. D.

12/16, 1923 (Address) 701 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oakland Cemetery	Dec. 21, 1922.

20-UNDERTAKER.	ADDRESS
Zirkler + Zirkler	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81855

D 81855

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4910 Reisterstown ST., ... WARD)

2-FULL NAME Thomas F Jones

(a) RESIDENCE No. 4910 Reisterstown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 (Single, Married, Widowed, or Divorced (write the word)) Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Genevieve Jones

6 DATE OF BIRTH (month, day, and year) Jan 26-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Automobile 031
(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Richard J.C. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER V. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas. F. M. Jones
(Address) 4910 Reisterstown

15 Filed ..... 192 ..... Registrar
DEC 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ueo Dietary

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hennessy, M. D.
(Coroner.)

Dec. 17, 1923 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral (new) DATE OF BURIAL Dec 20 1923

20 UNDERTAKER Wm Cook & Co ADDRESS 502 E. Balto St

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81856

CERTIFICATE OF DEATH.

199 D 81856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E. Henrietta ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Della Nash

(a) RESIDENCE. NO. 26 E Henrietta ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/11/04

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	11	35	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Burnett Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Dalgefe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs Della Fisher - 26 E Henrietta St

15 Filed DEC 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dec 17 1923 5 Inquest necessary Otto M Reinhardt Coroner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/26 1923 to 12/16 1923 that I last saw h alive on 12/16 1923 and that death occurred, on the date stated above, at 12:55 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (secondary) Peritonitis (following Self induced abortion)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown, M. D.

, 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Dec 18 1923
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

Perry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 31857

100-001

D 31857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 910 W Lombard ST.; 18 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katharine Gratton Preston Perry

(Residence in Baltimore: No. 910 W Lombard St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Dec. 5th, 1923
(Month) (Day) (Year)

7-AGE, ...yrs. 13 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): NO

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Bernard F. Perry

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Katherine Gratton Preston

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard F. Perry

(Address) 910 W. Lombard St.

15- DEC 18 1923 ROBERT B. KRAUTER, Registrar.
Filed ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 18, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1923, to Dec 18 1923, that I saw her alive on Dec 17 1923, and that death occurred, on the date stated above, at 3 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(Primary) (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) ....., (Duration) ....yrs. ....mos. ....ds.

(Signed) C. Charles Cunningham M. D.

Dec 18, 1923 (Address) 701 St. Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bonnie Brae Cem. DATE OF BURIAL, Dec. 17, 1923

20-UNDERTAKER George F. Smith ADDRESS 153 L Hollins St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 & 417 D 81858 — 129 D 81858

CERTIFICATE OF DEATH.

REGISTERED NO.

1 PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Minnie Weidinger

(a) RESIDENCE NO. 3507 Hudson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 22 | Months ? | Days ? | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Factory Work

(b) General nature of industry, business, or establishment in which employed (or employer): Mfg Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER George Weidinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: JOHNS HOPKINS HOSPITAL. (Address): Personally ROBERT R. KRAUTER

15 Filed DEC 18 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Dec 16, 1923, that I last saw h.. alive on Dec 16, 1923, and that death occurred, on the date stated above, at 7.00 P. M.

The CAUSE OF DEATH* was as follows:

Pericarditis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Walter B. Stewart M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. — DATE OF BURIAL: Dec 19 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Mo[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

Emma E. Stoner

D 31859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 31859

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2548 Frederick St., 9A WARD)

2-FULL NAME Emma E Stoner

(a) RESIDENCE NO. 2548 Frederick St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Stoner

6 DATE OF BIRTH (month, day, and year) March 13-1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Fickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Glass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Stoner (Address) 2548 Frederick Ave.

DEC 18 1923 Filed 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/16 1923

17

I HEREBY CERTIFY, That I attended deceased from 7/12, 1923 to 12/16, 1923.

that I last saw h alive on 12/12, 1923.

and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Condition

Duration yrs. mos 1 ds.

CONTRIBUTORY (Secondary)* Chronic Nephritis

duration yrs. 5 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Ex

(Signed) James F. Hickey M. D.

12/17 1923 (Address) 1727 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mayo Cathedral	Dec 19 1923

20 UNDERTAKER George L Schwab ADDRESS 701 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81860

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Vincent ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Elizabeth Purdy

(a) RESIDENCE No. 318 S. Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Elridge Purdy

6 DATE OF BIRTH (month, day, and year) June 1, 1859

7 AGE Years 64 Months 6 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baeto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Martha Dorman

(Address) 520 N Mount St

15 Filed OCT 9 1923, 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923 to Dec 16, 1923, that I last saw her alive on Dec 14, 1923, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) Indefinite ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. A. Howell M. D.

12/8/1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Lawn — DATE OF BURIAL Dec 19 1923

20 UNDERTAKER Brown & Freeland — ADDRESS 114 N Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form must be answered. Omission of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICAL CERTIFICATE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81861

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Euson ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miles Murray

(a) RESIDENCE NO. 1615 Euson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Murray

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ines Melroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Murray (Address) 1615 Euson St

15 Filed DEC 18 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18 1923

17

I HEREBY CERTIFY, That I attended deceased from 10/23, 1923, to 12/18, 1923, that I last saw h[illegible] alive on 12/17, 1923, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) D Belmont Lowe, M. D.

12/18 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Dec 20 1923

20 UNDERTAKER H C Wiedefeld 914 Druid Pk — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81862

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 10 WARD)

2-FULL NAME G. Harry Whitemore

(a) RESIDENCE NO. 1033 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) April 19/1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Elevator man
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. B. Whitemore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Catherine Whitemore
(Address) 1033 Greenmount Ave.

15 Filed ..., 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

DEC 19 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Post operative Pneumonia

(Olive lodged in Gullet below larynx Dec 14/23) while at supper.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Callen (Coroner), M. D.

Dec 17/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 19 1923
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81863

CERTIFICATE OF DEATH.

109-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 Valley St ST., 9 WARD)

2-FULL NAME Anna Marie Byrne

(a) RESIDENCE No. 1306 Valley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4, 1913

7 AGE — Years: 10 — Months: 00 — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Laurence J Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Walter C Bacon

(Address) 100 E 20th St

15 Filed ..... 19 .....

Registrar

DEC 18 1923

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Dec 17, 1923,

that I last saw h alive on Dec 17, 1923,

and that death occurred, on the date stated above, at 3 Am m.

The CAUSE OF DEATH* was as follows:

Endocarditis (20 yrs)

(duration) yrs. 1 mos + ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter C Bacon M. D.

12/17 1923 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: Dec 19 1923

20 UNDERTAKER: Id. C. Wedefeld — ADDRESS: 914 Greenmount

PLEASE WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tonsilitis
Acute Arthritis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81864

CERTIFICATE OF DEATH.

147

D 81864

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3011 Philadelphia Ave 6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite N Lily

(a) RESIDENCE NO. 6013 Liberty Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Schanbr E Lily

6 DATE OF BIRTH (month, day, and year) June 6 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alex Frysckel

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Ella R Wagaman

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Frank Yokel

(Address) 6013 Liberty Heights Ave

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 17 Dec 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1923, to Dec 17, 1923,

that I last saw h 5 alive on Dec 17, 1923

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Delivery & Child

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William H Lyssander M. D.

19 (Address) 801 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loran cemetery

DATE OF BURIAL: Dec 20 1923

20 UNDERTAKER: Wilbur H Shreve 1918 E Monument Ave

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 181923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81865

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1103 N. Eutaw St., 13 WARD)

2-FULL NAME Harry E. Pilgrim

(a) RESIDENCE No. 1103 N. Eutaw St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Florence E. Pilgrim

6 DATE OF BIRTH (month, day, and year): Sept. 15. 1872

7 AGE — Years: 51 — Months: 3 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer 34

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Maryland

PARENTS

10 NAME OF FATHER: H. C. Pilgrim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan J. Hann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs. Florence E. Pilgrim 1103 N. Eutaw St

15 Filed DEC 18 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to Dec 18, 1923, that I last saw h alive on Dec 17, 1923, and that death occurred, on the date stated above, at 3.25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Carcinoma of Intestines

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Carcinoma + Metastasis

Carcinoma (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic test

(Signed) Herbert M. Foster, M. D.

Dec 18 1923 (Address) 924 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Mary's, Hampden — DATE OF BURIAL: Dec 20 1923

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

Seidel D 81866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81866

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 N. Payson ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Seidel

(a) RESIDENCE NO. 1503 N. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Kravietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Perta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Kalman Seidel

(Address) 1503 N Payson St

15 DEC 18 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-18-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec-16-1923, to Dec-18-1923, that I last saw her alive on Dec-18-1923, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Seidel M. D.

12/18, 1923 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Henrig Run	12/18 1923
20 UNDERTAKER	ADDRESS 1127
Sol Levinson & Bro	E. Balto St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar

Spec.—1-10-21—M&T—1500 Bks.

McClara 401 N Payson

D 81867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 81867

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Edmondson Av ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Lillian Erler

(a) RESIDENCE No. 2111 Edmondson Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Herman F. Erler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Edith Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr Herman Erler

(Address) 2111 Edmondson Ave

15 Filed DEC 18 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1923 to Dec 17 1923

that I last saw her alive on Dec 17 1923

and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Erysipelas

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj F McCleary, M. D.

12/7, 1923 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 19 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fay Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81868

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2020 E. Biddle ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa E. Betzel

(a) RESIDENCE No. 2020 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Male

6 DATE OF BIRTH (month, day, and year) Mar 29/1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	8.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Valentine Betzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rosie Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rosa Betzel (Address) 2020 E. Biddle

15 Filed ....., 19..... Robert P. Harrison, Registrar

DEC 18 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17- 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 10- , 1923, to Dec. 17- , 1923, that I last saw h.. alive on Dec. 17- , 1923, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Rheumatism of the Heart (duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Edwin B. Feaby, M. D.

12/19/1923 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 19 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-00 D 81869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 W. Fayette St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony J Curtin

(a) RESIDENCE NO. 1523 W. Fayette St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3 Weeks 22 Days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Fredrick Curtain

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Catherine Liberto

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Catherine Curtin (Address) 1523 W. Fayette ave

15 Filed ..... 19 .....

Registrar

Robert F. Harrison, Burial Permit Clerk

DEC 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 26 1923, to Dec 18 1923, that I last saw him alive on Dec 16 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6½ month Gestation.

Stillborn (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Yohalem M. D.

Dec 18 1923 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 19 1923
20 UNDERTAKER	ADDRESS
Thomas J. Ruth	1735 Harford Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81870

CERTIFICATE OF DEATH.

74 D 81870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Goat

(a) RESIDENCE NO 2820 Clifton av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	53.	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brush maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer W. Schultz & Co

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Mr Goat

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER C. Lein

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Bro Goat
(Address) 2820 Clifton av

15 Filed ..., 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Sudden (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

(Signed) [illegible], M. D.
(Coroner.)

Dec 18, 1923 (Address) 1043 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Dec 19 23
20 UNDERTAKER Jos Jacobs Son	ADDRESS 2178 Pa av

TION is very important. See instructions on back of certificate.

D 81871 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-09 81871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 315 E 28 St St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Penelope A Armstrong

(Residence in Baltimore: No. 315 E 28 St St.; 2/12 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

6-DATE OF BIRTH. Sept 15 1864
(Month) (Day) (Year)

7-AGE, 59 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) D 3

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER. Geo L Anderson

11-BIRTHPLACE OF FATHER, (State or Country). md

12-MAIDEN NAME OF MOTHER. Pulli Dawson

13-BIRTHPLACE OF MOTHER, (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth E Armstrong

(Address) 315 E 28 St

15- Dec 19 1923 Robert P. Harrison, Registrar.

DEC 19 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno T Morrissey M. D.
(Coroner.)

Dec 19 1923 (Address) 3572 Roland

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, Balto Co Sherwood Mem Dec 19 1923

20-UNDERTAKER, ADDRESS CHENOWETH & SON, 3617 CHESTNUT AVE.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec--12-23-21--E.B.K.S.--400 Bks.

(Goodman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81872

CERTIFICATE OF DEATH.

179 D 81872

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 725 Aisquith st St., 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Luciano Bongiorno Goodman

(a) Residence No. 725 Aisquith st St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Teodosia Palermo

6-DATE OF BIRTH (month, day and year) 1862

7-AGE, 61 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... cook

(b) General nature of industry, business, or establishment in which employed (or employer)..... 600

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Italy

PARENTS.

10-NAME OF FATHER Calogero Bongiorno

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Paolina Profeta

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy

14- (Informant) Wilhelmina B. Goodman

(Address) 725 Aisquith st.

15- Filed DEC 18 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/16/23.

17- I HEREBY CERTIFY, That I attended deceased from June 9 1923 to Dec 16 1923

that I last saw him alive on Dec 16 1923,

and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D

12/17, 19 (Address) 733 Aisquith St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. | DATE OF BURIAL, 12/19/23, 19....

20-UNDERTAKER, Geo J. Ruth | ADDRESS 1735 Harford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificates.

DEC 18 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81873

CERTIFICATE OF DEATH.

+15 D 81873

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Henry Banks.

(a) **RESIDENCE** No. 69 Wentz's Ave ST., Catonsville WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 1240

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Green Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Louisa Reedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Hospital Records.

(Address)

15 DEC 19 1923 ROBERT R. KRAUTER, Registrar

DEC 19 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/17/23

17

I HEREBY CERTIFY, That I attended deceased from 12/7/23, 19..., to 12/17/23, 19....

that I last saw h— alive on 12/12/23, 19....

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pyaemia Loc mal.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Gangrene of Leg.

Laborer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ? amputation of leg

Did an operation precede death? Yes Date of 12/8/23.

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) K. W. Hockley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa. DATE OF BURIAL Dec 19 1923

20 UNDERTAKER Mrs R.G. Elliott ADDRESS 1725 Eastland

Spec.—6-9-19—H. P. Co.—1000 Bks.

Corbin

D 81874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 ✓

D 81874

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Mace st ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Corbin

(a) RESIDENCE. NO. 2022 Mace ST., WARD. Augusta

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Talbot Corbin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 45	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Upperville Va "

PARENTS

10 NAME OF FATHER Thomas Sidus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Upperville, Va "

12 MAIDEN NAME OF MOTHER Betty Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va "

14 Informant Bell Lewis

(Address) 2022 Mace st

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 19 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923, to Dec 15, 1923, that I last saw h[illegible] alive on Dec 16, 1923, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Upperville Va "

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) R. A. Johnson M. D.

19 (Address) 211-E-23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Upperville Fauquier Co Va	Dec 19 1923

20 UNDERTAKER Mrs R. G. Elliott

ADDRESS 1728 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81875

CERTIFICATE OF DEATH.

D 81875

101-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Aisquith St ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida M. Morgan

(a) RESIDENCE NO 1920 Aisquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Morgan

6 DATE OF BIRTH (month, day, and year) Jan 10/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs . R. A.Elliott
(Address) 1725 Ashland Ave.

15 Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17/23 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Pullen, M. D. (Coroner.)

Dec 18/23 '92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	12/23 1923
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 81876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81876

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Johnson

(a) RESIDENCE NO 1231 1/2 Mullican ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Brown

6 DATE OF BIRTH (month, day, and year) Mar 8 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Mrs. R.A.Elliott (Address) 1725 Ashland Ave.

15 Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insuffiency

(Autopsy at Hopkins Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Powers, M. D.
(Coroner)

Dec 18/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Crem	12/21 1923
20 UNDERTAKER	ADDRESS
Mrs R.A. Elliott	1725 Ashland

Remarks.....

Syphilis

.....

.....

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D 81877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 ✓ D 81877

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2538 Tait ave ST. 1 WARD)

2-FULL NAME Gerhard T. Anderson

(a) RESIDENCE NO. 2538 Tait Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith M. Anderson

6 DATE OF BIRTH (month, day, and year) Oct 23rd 1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER August Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Lena Knoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Edith M. Anderson

(Address) 2538 Tait Ave.

15 Filed DEC 19 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22 1923, to Dec. 16 1923, that I last saw him alive on 16 1923, and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

Centrum of Thighmore

(duration) 1 yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of July 1922

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) Chas. E. Tiller, M. D.

12/17/23 (Address) 408 Park Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Town Cemetery — DATE OF BURIAL: Dec 19 1923

20 UNDERTAKER: Lilly & Tiller — ADDRESS: 400 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81878 D 81878

CERTIFICATE OF DEATH.

REGISTERED NO. 128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S. Highland Ave. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Dotterweich.

(a) RESIDENCE. No. 27 S. Highland Ave. 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 4 mos. 23 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Dotterweich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Spiegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Jacob Dotterweich Father 27 S. Highland ave

15 Filed DEC 19 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-17 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1923, to Dec 17, 1923, that I last saw h[illegible] alive on Dec 17, 1923, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Pulm Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? own

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Wales, M. D.

1923 (Address) 3323 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 21st 1923

20 UNDERTAKER Lilly Zeiler

ADDRESS 4031 Hoyt

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks. Daniel Mc Clenen Bond.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81879

CERTIFICATE OF DEATH.

89

D 81879

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 236 N. Luzerne Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Mc Clenan Bond

(a) Residence No. 236 N. Luzerne Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Bond

6-DATE OF BIRTH (month, day and year) Jan 1, 1871

7-AGE. 62 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). Water Department

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Caleb F. Bond

11-BIRTHPLACE OF FATHER (city or town) Mich.
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary E. Shaney

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country), Md.

11-Informant) Annie Bond

(Address) 236 N. Luzerne Ave

DEC 19 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 16/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1923 to Dec 16 1923, that I last saw him alive on Dec 16 1923, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Sage M. D

12/18 1923 (Address) 918 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Dec. 19, 1923

20-UNDERTAKER, H. Sander Sons ADDRESS 1210 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81880

81880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 240 Rock ST., 18 WARD)

2-FULL NAME Florence Anthony

(a) RESIDENCE No. 240 Rock ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Female~~	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. A. Anthony

6 DATE OF BIRTH (month, day, and year) Aug 28 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	53	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cultreville Md

PARENTS

10 NAME OF FATHER Frederick Jolens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Violet Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Shore Md

14 Informant Ellsworth Jones

(Address) 240 Rock N

15 DEC 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Bureau

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Dec 16, 1923, that I last saw her alive on Dec 15, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. ... mos 15 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W J Howell M. D.

Dec 19, 1923 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12/19 1923
20 UNDERTAKER	ADDRESS
Samuel Reynolds	Balto

Cor.—1-12-23—M&T—100 Bks.

D 81881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N Riley ✓ 188-003 D 81881

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 11 Mercy Hospital ST., 8 WARD)

2-FULL NAME Samuel F. Krauss

(a) RESIDENCE No 1801 North Chester ST., Essex WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Krauss

6 DATE OF BIRTH (month, day, and year): Feb 1 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031
(c) Name of employer: Pure Bro's

9 BIRTHPLACE (City or town) (State or country): Washington D. C

PARENTS

10 NAME OF FATHER: Wm Krauss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Samuel F Krauss
(Address) 1801 N. Chester St

15 Filed ..... 192 ..... ROBERT R. KRAUTER Registrar

DEC 19 1923 Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull
Accidentally Struck by auto

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) M Riley, M. D.
Dec 18, 1923 (Address) 639 Cathedral (Coroner.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington, D. C

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U. S. National — DATE OF BURIAL: 12/20 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS should state very important. See instructions on back of certificate.

Cor.--1-12-23--M&T--100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81882

CERTIFICATE OF DEATH.

167 D 81882

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 Lloyd ST., 3 WARD)

2-FULL NAME Frank. Grigonis or Grigonis

(a) RESIDENCE NO. 232 Lloyd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE 45 Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labar
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Andrus Grigonis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Anne Milinckas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14
Informant John Miler
(Address) 26 S Albermarle Street

15
Filed DEC 19 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Suicide

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas Schulz, M. D.

Dec 18 1923 (Coroner.) (Address) 1430 Mc Henry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec. 20. 1923

20 UNDERTAKER John Grebliauckas — ADDRESS 425 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81883

CERTIFICATE OF DEATH.

113

D 81883

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 South Eutow St., 22 WARD)

2-FULL NAME Frence Navyelis

(a) RESIDENCE No. 218 S. Eutow ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Sept. 10. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X		3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Navyelis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER M. Cizavckas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

14 Informant Joseph Navyelis
(Address) 218 S Eutow Street

15 Filed DEC 19 1923 ROBERT R. KRAUER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Decmb. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Decmb. 12 1923 to 18 Decmb. 1923, that I last saw h.[illegible] alive on 18 Decmber 1923, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

a. Influenza

.....

.....

.....

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81884

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 295 r Hartford Rd St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Barbara Ruppreckt

(a) Residence No. 295 r Hartford Rd St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, ~~or Divorced.~~ (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Christian Ruppreckt

6-DATE OF BIRTH (month, day and year) June 9 1838

7-AGE. 85 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Bavaria Germany

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Don't know

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Don't know

14- (Informant) Emma Ruppreckt

(Address) 295 r Hartford Road

15- Filed ..... 19.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 17 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24, 19 23, to Dec. 17, 19 23,

that I last saw her alive on Dec 17, 19 23,

and that death occurred, on the date stated above, at 1-10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Wm J Schmidt M. D.

Dec 18, 1923 (Address) 701 N Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Dec 21 ..... 19 23

20-UNDERTAKER. R. Heemann. ADDRESS 324 Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 31885

HEALTH DEPARTMENT—CITY OF BALTIMORE

167-001 D 81885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Arlington Av ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin C. Hammond

(a) RESIDENCE No. 604 N. Arlington Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
(or) WIFE of Alice E. Hammond.

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City
(c) Name of employer 634

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Richard Hammond

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Carver

13 BIRTHPLACE OF MOTHER (city or town) Penna.
(State or country)

14 Informant Walter M. Hammond
(Address) 604 N. Arlington Ave.

15 Filed DEC 19 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jur (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

suicide by gas inhalation (gas stove)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hammond, M. D.
(Coroner.)

Dec. 19, 1923 (Address) 730 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Dec. 19 1923

20 UNDERTAKER John A. Mitchell ADDRESS 120 N. Fayette St.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81886

CERTIFICATE OF DEATH.

101-001 D 81886

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 Forrest ST., 10 WARD)

2-FULL NAME Frances A. Broderick

(a) RESIDENCE NO. 929 Forrest ST., 10 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of November 14, 1861

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
62	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frances A Broderick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Farley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James F Conaty (Address) 2420 E Oliver St

15 Filed DEC 19 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/17 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/16, 1923, to 12-17, 1923, that I last saw h[illegible] alive on 12-16, 1923, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Hoffman Lobb, M. D.

12/19, 1923 Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 12/20 1923

20 UNDERTAKER George J Ruth — ADDRESS 1785 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81887

CERTIFICATE OF DEATH.

3/ D 81887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Colvin ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertie Jones

(a) RESIDENCE NO. 112 N. Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Age Given 30 or 32 -			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Washington D C
(State or country)

14 Informant Mrs Butler
(Address) 112 Colvin

15 Filed DEC 19 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmon. tuberculosis
Dont know

(duration) yrs. Patient Long time

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

(Signed) W. S. Riley, M. D.
(Coroner.)

Dec 18. 1923 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Dec 20 1923

20 UNDERTAKER John W Henderson

ADDRESS 1807 E. Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 81888

81888

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 E. Biddle ST., 10 WARD)

2-FULL NAME Maude Holter

(a) RESIDENCE NO. 1229 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard J. Holter

6 DATE OF BIRTH (month, day, and year): July 25, 1887

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
36	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Charles Keck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lillie Stultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Howard J. Holter 1229 E. Biddle

15 Filed ..., 19... ROBERT R. KRAUTER, Registrar

Burial Permit Issued DEC 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1923, to Dec 17, 1923.

that I last saw her alive on Dec 16, 1923,

and that death occurred, on the date stated above, at 5.50 A.M.

The CAUSE OF DEATH* was as follows:

Pulm T.B.

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

12/18/23 (Address) 1235 E. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: 12/20 1923

20 UNDERTAKER: Sinkler & Sinkler

ADDRESS: 1234 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Winters

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 ✓

D 81889

CERTIFICATE OF DEATH.

D 81889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 N. Bond ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca A Winters

(a) RESIDENCE NO. 1129 N Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Jno. A. Winters

6 DATE OF BIRTH (month, day, and year) June 26, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Saml. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Robt. J. Winters

(Address) 1730 E. Madison

15 Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 1923 to Dec 18, 1923.

that I last saw he alive on Dec. 17, 1923,

and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. B. Britton M. D.

. 19 (Address) 1711 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 20 1923

20 UNDERTAKER John Merrick

ADDRESS 200 E Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81890

CERTIFICATE OF DEATH.

124 D 81890

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Linden Ave ST., 14 WARD)

2-FULL NAME James W. Robinson

(a) RESIDENCE NO. 2044 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Aug 11/52

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer) general plumbing business

(c) Name of employer self

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Richard Robinson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Horan

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mrs Ella Robinson

(Address) 2044 Linden ave

15 DEC 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1923, to Dec 17, 1923, that I last saw him alive on Dec 17, 1923 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Enlarged liver & jaundice

(Ultimate)

Interstat (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) gastric hemorrhage 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Krantz, M. D.

Dec 5, 1923 (Address) 1002 N Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet bur

DATE OF BURIAL Dec 20 1923

20 UNDERTAKER W M Rowlson

ADDRESS 2238 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 81891

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1159 Calhoun ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Holly

(a) RESIDENCE. NO. 1159 Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Died

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 18 1923

7 AGE: Years — Months 4 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Viola Holly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Viola Holly
(Address): 157 Woodyard St

15 Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/18/23

17 I HEREBY CERTIFY, That I attended deceased from 12-18-, 1923, to 12-18-, 1923, that I last saw h[illegible] alive on 12-18-, 1923, and that death occurred, on the date stated above, at 1:40 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W K Bakus, M. D.

. 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Dec 20 1923
20 UNDERTAKER	ADDRESS
Garner & Wright	864 Fremont

N. B.—WHITE FEMALE, MARRIED, DIED CHILDBIRTH. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81892

D 81892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 621 St. Paul St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cohen

(a) Residence No. 621 St. Paul St., Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jacob Cohen

6-DATE OF BIRTH (month, day and year) April 17, 1864

7-AGE, 59 yrs. 8 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Abraham Himan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Dora —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-Informant Mr. Jacob Cohen

(Address) 621 St. Paul St.

15-Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/19/23.

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Dec 19th, 1923, that I last saw h[illegible] alive on Dec 15, 1923, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma 1 Stomach and esophagus

(Duration) 1 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Examination

(Duration) yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray examination

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1013 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Har Sinai Cem. DATE OF BURIAL, 12/21/, 1923

20-UNDERTAKER, David Sondheim ADDRESS 1820 W. Mt. Royal Ave.

All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81893

CERTIFICATE OF DEATH.

74-001 D 81893

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Harlem Ave St.; 16 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Helen Abell

(Residence in Baltimore: No. 1114 Harlem ave St.: Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, October (Month) 15 (Day), 1855 (Year)

7-AGE,	If LESS than 1 day,
68 yrs. 2 mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas W Cromer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rebecca Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Abell

(Address) 1114 Harlem Ave

15- Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1923, 191... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st last 191..., to 23 years 191...,
that I saw her alive on Dec. 17 1923,
and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Death Instantaneous
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(Duration) 8 yrs. 11 mos. [illegible] ds.
(Signed) Edwin C Smith M. D.
12-15..., 1923 (Address) 1532 Hollins st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cem	Dec. 16..., 1923
20-UNDERTAKER George F Smith	ADDRESS 1532 Hollins st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81894 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81894

CERTIFICATE OF DEATH. X60-002

1-PLACE OF DEATH U.S. Marine Hospital 201.

CITY OF BALTIMORE: (No. Baltimore, Md. ST., 17 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence W. Davis.

(a) RESIDENCE No. U.S. Marine Hospital ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) oiler

(c) Name of employer G/S Weir Greylock.

9 BIRTHPLACE (city or town) (State or country) Reedville, Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jeff Clarence W Davis
(Address) U.S. Marine Hosp

15 Filed DEC 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1923, to Dec 18, 1923, that I last saw him alive on Dec 18, 1923 and that death occurred, on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH* was as follows:

Goitre Toxic adenomatous,
Toxic myocarditis with
cardiac failure

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Dec 17/23

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) W. N. Hall, M. D.

19 (Address) Marine Hospital Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Timbo. Warf Va	12/19/23
20 UNDERTAKER	ADDRESS
A. Gleinson & Bro	E. Balto St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81895

168 D 81895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3715 Fait Ave ST., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Demling

(a) RESIDENCE No. 3715 Fait Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine Demling

6 DATE OF BIRTH (month, day, and year) Sept 14 1873

7 AGE Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
50	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Michael Demling

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Catherine Demling
(Address) 3715 Fait Ave

15 Filed ..... 192 ..... Registrar

Robert P. Harrison
Burial Permit Clerk.

DEC 19 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging
Self
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Norton, M. D.
(Coroner.)

Dec 17th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Dec. 20 1923
20 UNDERTAKER Lilly & Zeller	ADDRESS 403 S. Wolfe St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81896

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-09

D 81896

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3317 Hudson St. ST., 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawson St. Gudr.

(a) RESIDENCE NO. 3317 Hudson St ST., 26 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Gudr.

6 DATE OF BIRTH (month, day, and year) June 19-184[illegible]

7 AGE: Years 81 | Months 5 | Days 29 | If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer) D'k

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Lawson St. Gudr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Mary B. Metzger

(Address) 3317 Hudson St.

15 Filed ....., 19.... Registrar

Robert P. Harrison,

Burial Permit Clerk.

DEC 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1923.

17

I HEREBY CERTIFY, That I attended deceased from December 5, 1923, to December 18, 1923, that I last saw h/m alive on December 17, 1923, and that death occurred, on the date stated above, at 1.55 a. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

(duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) .... yrs. .... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb H. Riley, M. D.

Dec. 19, 1923 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem.

DATE OF BURIAL: Dec 21 1923.

20 UNDERTAKER: Lilly and Zuke

ADDRESS: 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1919 Linden Ave St., 14 Ward) Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carrie Levy

(a) Residence No. 1919 Linden Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Lyons Levy

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 84 yrs. — mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Abraham Jafotowitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Leah

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

13- (Informant) Anna Levy

(Address) 1919 Linden Ave

15- Filed 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

DEC 19 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 19-1923

17- I ~~HEREBY~~ CERTIFY, That I attended deceased from Dec 10 1923 to Dec 19 1923

that I last saw ~~her~~ alive on Dec 18 1923,

and that death occurred, on the date stated above, at 6.9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Lilly Jr. M. D.

. 19 (Address) 1910 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Friendship — DATE OF BURIAL. 12-21-23

20-UNDERTAKER. Jack Lewis — ADDRESS 1409 E Balt

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81898 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81898

CERTIFICATE OF DEATH. 146

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 22 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline Armstrong

(a) RESIDENCE NO. 5th Ave & Marshall Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Armstrong

6 DATE OF BIRTH (month, day, and year) Oct 8 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	2	9	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gallia County Ohio

PARENTS

10 NAME OF FATHER Charles Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gallia Co. Ohio

12 MAIDEN NAME OF MOTHER Sarah Jane Crum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gallia county Ohio

14 Informant Miss Cynthia Cook

(Address) Gallipolis Ohio - Rural #1

DEC 19 1923 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1923, to Dec. 19, 1923,

that I last saw him alive on Dec. 19, 1923,

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Streptococcus haemolyticus)

Blood stream infection

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + lab. signs

(Signed) [illegible], M. D.

, 19 (Address) Mt Olive Steps

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gallipolis Ohio.

DATE OF BURIAL Dec 19 1923

20 UNDERTAKER Wendell Dippel & Son

ADDRESS 378 Main

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~16 D 81899~~ 113 D 81899

CERTIFICATE OF DEATH

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 6

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Eugene Balon

(a) RESIDENCE No. 28 N. Durham St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct 17 1923

7 AGE Years ..... Months 2 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Eugene Balon

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Martha Konopka

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... 19 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

C 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1923, to Dec 19, 1923, that I last saw him alive on Dec 19, 1923, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute gastro-intestinal indigestion

Toxic nodes (duration) ..... yrs. ..... mos. 11 ds.

18 Where was disease contracted if not at place of death? at home (Campbell cold)

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Caspar Taussig, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Dec. 20 1923

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on ... of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81900

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 81900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 E Preston ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannie Hudek

(a) RESIDENCE NO. 1303 E. Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 69

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austra

PARENTS

10 NAME OF FATHER Emanuel Hajek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austra

12 MAIDEN NAME OF MOTHER Mary Penesch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Sterling Hudek

(Address) 1303 E Preston St

15 Filed ..., 19... Robert P. Harrison, Registrar

DEC 19 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923 to Dec 18, 1923.

that I last saw her alive on Dec 18, 1923

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 5 mos ... da.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Weston Magruder, M. D.

(Address) 8014 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL Dec 20 1923

20 UNDERTAKER J. Abrams & Son

ADDRESS ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81901 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D 81901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. CITY OF BALTIMORE: (No. ... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Stewart

(a) RESIDENCE NO. Burlington Hotel ST., Washington D. C. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of Preston Stewart

6 DATE OF BIRTH (month, day, and year) Dec 4, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69 yrs	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS
10 NAME OF FATHER David Williams
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.
12 MAIDEN NAME OF MOTHER Mary Smith
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL.

15 C 19 1923 — 19 — Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17
I HEREBY CERTIFY, That I attended deceased from Nov 8, 1923, to Dec 19, 1923, that I last saw her alive on Dec 19, 1923, and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma, Colloid, of Gall Bladder.
(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Peritoneal carcinomatosis
(duration) ... yrs. 1 mo ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? Yes Date of 7-9-23 11-17-23
Was there an autopsy? No
What test confirmed diagnosis? Microscopic examination of operative spec.
(Signed) Cecil H. Bagley, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakmont, Va — DATE OF BURIAL: Dec 20, 1923

20 UNDERTAKER: Wm Levy & Son Eutaw and — ADDRESS

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... may be important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 81902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81902

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hosp. ST., 27 (WARD)

2-FULL NAME Ella Robinson Watkins

(a) RESIDENCE NO. South Ave. Mt. Washington ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 64 yrs. 3 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rev. Wilbur F. Watkins Jr.

6 DATE OF BIRTH (month, day, and year): Aug-22-1859

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	64	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Philadelphia Penna

PARENTS

10 NAME OF FATHER: William Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown England

12 MAIDEN NAME OF MOTHER: Sarah Paterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Scotland

14 Informant: Rev. W. F. Watkins Jr. (Husband)

(Address) Mt. Washington City

15 Filed DEC 19 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from November 20, 1923, to December 18, 1923, that I last saw her alive on December 18, 1923, and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

Extension to liver

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 26, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and Autopsy

(Signed) C. H. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Dec 20 19 23

20 UNDERTAKER: STEWART & MOWEN COMPANY (Successors to)

ADDRESS: 108 W. NORTH AV

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may b TION is very important. See instructions on back c

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81903

CERTIFICATE OF DEATH.

(City) Off Park Heights ave

D 81903

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 12 Cornhill Road (WARD) 27

2-FULL NAME Harold W. Byers Jr.

(a) RESIDENCE No. 12 Cornhill Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Harold W. Byers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Mabel E. Lire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harold W. Byers
(Address) 12 Cornhill Road

15 Filed DEC 19 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1923, to Dec 19, 1923, that I last saw h[illegible]ive on Dec 19, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Primary)
(duration) yrs. mos 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Homer L. Todd M. D.

12/19, 1923 (Address) 735 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Dec 21 1923

20 UNDERTAKER Mr & Mrs. John W. Teufel & Son — ADDRESS 801 W Fayette

DEC 19 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 ✓ D 81904

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

2-FULL NAME Chas R Rhodes

(a) RESIDENCE NO. 1531 N Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colr	Marrd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Jerry Rhodes

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Harmon

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Rebecca Frankson
(Address) 1531 Bruce St.

15 Filed ..... 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

DEC 19 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.)....
thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.)....
find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bruised Wound

(duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Died from Lock Jaw

(duration) ....yrs ....mos. ....ds.

(Signed) W K Bonsal, M. D.
(Coroner.)
, 192 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	12/20 1923
20 UNDERTAKER C. James A. Dennis	ADDRESS, 303 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 81905

CERTIFICATE OF DEATH.

101 D 81905

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3112 Berkshire Road St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Donald Shannon MacDermott

(Residence in Baltimore: No. 3112 Berkshire Road (Arcadia) St.; 1 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White.	Single

6-DATE OF BIRTH, November (Month) 8 (Day), 1918 (Year)

7-AGE, 4 yrs. 1 mos. 10 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child —
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Walter Jefferies MacDermott

11-BIRTHPLACE OF FATHER (State or Country), Fairview Penna

12-MAIDEN NAME OF MOTHER Edith May Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. C. Shannon

(Address) 700 Fulton Ave

15- Filed ... 191... Robert J. Garrison, Burial Permit Registrar.

DEC 19 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, DEC (Month) 19 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ... 191..., to Dec 19 1923, that I saw him alive on Dec 19 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: See note on back.

(1) Pneumonia (Lobar)

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis Acute

(Duration) ... yrs. ... mos. 10 ds.

(Signed) George C. Shannon M. D.

Dec 19, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Dec 21, 1923

20-UNDERTAKER Jos. L. Cook ADDRESS 1023 N. Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81906

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1520 Kensett St. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Arthur Garfield Bentz

(a) Residence No..... 1520 Kensett St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eva May Bentz

6-DATE OF BIRTH (month, day and year) Oct. 6, 1881

7-AGE, 42 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (City or town) Westminster Carroll County
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Bentz

11-BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country),

14- (Informant) Mrs. Eva May Bentz

(Address) 1520 Kensett St.

15- Received DEC 19 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1923, to Dec. 17, 1923, that I last saw him alive on Dec. 17, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Frank L. Ogden, M. D.

12-17, 1923 Address Dispensary Baker & Pa. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Olivet Cem. DATE OF BURIAL, Dec 19, 1923

20-UNDERTAKER, Geo. P. Cook ADDRESS 1003 N. Eutaw St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81907

HEALTH DEPARTMENT—CITY OF BALTIMORE

162

D 81907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 17 W. Gibbons Ave 27 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Giuseppe Di Domenico

(a) Residence No. 17 W. Gibbons Ave St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 8. 1923

7-AGE. ..... yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Agostino D'Domenico

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosina Loiacono

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14-

(Informant) Agostino D'Domenico

(Address) 17 W. Gibbons St.

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

EC 191923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/19/23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 18 1923 to Dec. 19 1923

that I last saw h.... alive on Dec. 19 1923

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hemophilia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY —

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Antigiani, M. D

, 19 (Address) 2942 E. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	12/20/23 19....
20-UNDERTAKER.	ADDRESS
Geo. J. Roth	1735 Harford Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162

D 81908

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 Carswell St.: 9 WARD)

2-FULL NAME George Edward Kampfer

(a) RESIDENCE. No. 1638 Carswell ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6 d	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath
(State or country) Md

PARENTS

10 NAME OF FATHER George Kampfer

11 BIRTHPLACE OF FATHER (city or town) Bath
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hart Murphy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant D Strassner
(Address) 2611 Eutaw St

15 Filed ..... 19 Robert P. Harrison
Registrar

Burial Permit Clerk.

DEC 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 192

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 192 3, to Dec 19, 192 3, that I last saw him alive on Dec 14, 192 3, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) instrumental delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Signs

(Signed) H. M. Bernard, M. D.

19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	12/20/23 19

20 UNDERTAKER Geo. J. Pabst ADDRESS 1735 Harford Ave

S.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81909 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81909

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. #16 S. Wolfe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Andrew Will

(a) Residence No. 16 S Wolfe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Barbra Will

6-DATE OF BIRTH (month, day and year) January 6 1846

7-AGE. 78 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant). Rev Michael Will

(Address).....

15- Filed DEC 19 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec-2- 19 23 to Dec 16- 19 23

that I last saw h— alive on Dec-16 19 23

and that death occurred, on the date stated above, at 12½ m.

The CAUSE OF DEATH* was as follows:

Malignant Dis. Liver (Carcinoma)

(Duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) [illegible] M. D.

, 19 (Address) 125 E [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Dec 20- 1923

20-UNDERTAKER. Wendell Duffieldson — ADDRESS 673 Hmm

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81910

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1238 Riverside Ave ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Quinn

(a) RESIDENCE NO. 1238 Riverside Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Sept 29 1923

7 AGE — Years: — Months: 2 — Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Michael J. Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mary R Holtzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary R. Quinn

(Address) 1238 Riverside ave

15 Dec 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 29 1923, to Dec 19 1923, that I last saw him alive on Dec 18 1923 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Mushaney M. D.

Dec 20 1923 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 12-20 1923

20 UNDERTAKER: Ehrle Hanke — ADDRESS: 115 E Lexington

C 1 1923

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81911

CERTIFICATE OF DEATH.

74-002 D 81911

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 14 WARD)

2-FULL NAME Mrs Pickey Knockey

(a) RESIDENCE No. 833 W North Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 9 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
64	—	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Bertie Strohmyer
(Address)

15 Robert F. Harrison, Registrar
....., 19 .....
~~Burial Permit Clerk~~

FC 197923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1923, to Dec 19, 1923,
that I last saw he alive on Dec 19, 1923,
and that death occurred, on the date stated above, at 1450 m.
The CAUSE OF DEATH* was as follows:
Cerebral Embolism (?)

(over)

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Infection Left Leg
(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 9/27/23

Was there an autopsy? Yes

What test confirmed diagnosis? Lab

(Signed) H V Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Germ. Evangelical	12/21/1923
20 UNDERTAKER	ADDRESS
David Sondheim	1820 W Mt Royal Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 81912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81912

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2669 Pennsylvania Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C Dorsey

(Residence in Baltimore: No. 2669 Pennsylvania St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1869 (Year)

7-AGE.	If LESS than 1 day,
54 yrs. mos. ds.	hrs. or mlu.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Garage

9-BIRTHPLACE, (State or Country): Balto Co

PARENTS.

10-NAME OF FATHER: Dennis Dorsey

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Cass

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Dorsey

(Address) 1921 W Fulton St

15- Filed ..... 192.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

C 191923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. 1 Dec (Month) 17 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Coronary Thrombosis
Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Bruckner M. D.
(Coroner.)

Dec 18 1923 (Address) 3602 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral	Dec 20 1923

20-UNDERTAKER.	ADDRESS
Martin Lahey & Son	837 W Saratoga

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81913

CERTIFICATE OF DEATH.

31

D 81913

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 E. Chase ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Carroll Boland.

(a) RESIDENCE NO. 928 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Boland.

6 DATE OF BIRTH (month, day, and year) Sept 1, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Boland.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Canby

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mary Boland. (Address) 928 E. Chase

15 Filed DEC 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 4th, 1923, to Dec 17th, 1923, that I last saw him alive on Dec 16th, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal and Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Signs

(Signed) L. McCarthy, M. D.

Dec 17, 1923 (Address) 111 W. Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	12/20 1923
20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Balto St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81914

CERTIFICATE OF DEATH.

101-001

D 81914

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 W. Lee ST., 22 WARD)

2-FULL NAME William Carpenter

(a) RESIDENCE NO. 627 W. Lee ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ——1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Jamaica B.W.I.

PARENTS

10 NAME OF FATHER Zechariah Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica B.W.I.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica B.W.I.

14 Informant Edward E. D. Johnson
(Address) 627 W. Lee St.

15 Filed DEC 20 1923 ROBERT R. KRAUS Registrar
Burial Permit Gr...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/17/1923

17

I HEREBY CERTIFY, That I attended deceased from 12/10/, 1923, to 12/17/, 1923, that I last saw h... alive on 12/17/, 1923, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

Influenza (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ben Bonley, M. D.

(Address) 938 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 20, 23
20 UNDERTAKER John H. Joadson	ADDRESS 142 Wilkens St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81915

CERTIFICATE OF DEATH.

19 D 81915

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aquired Boardley

(a) RESIDENCE No. 1114 Shields alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colr	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary Bordley (Address) 500 Johnson St.

15 Filed DEC 20 1923 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or ~~inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy or ~~inquiry~~) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in chest ow a few hours

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shot

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Jarrett, M.D. (Coroner.)

12-19, 1923 (Address) 1117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec 21 1923
20 UNDERTAKER	**ADDRESS**
Chas. H. Johnson & Co.	1617 Caroline St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81916

CERTIFICATE OF DEATH.

90 D 81916

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 Dumbarton ave ST., 9 WARD)

2-FULL NAME Antony B. Steigert

(a) RESIDENCE NO. 645 Dumbarton ave ST., 9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Mary M. Steigert

6 DATE OF BIRTH (month, day, and year): May 10 1861

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor at 086

(b) General nature of industry, business, or establishment in which employed (or employer): 7057 School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Steigert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs Mary M. Steigert 645 Dumbarton ave

15 Filed DEC 20 1923 ROBERT R. KRADER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1923, to Dec. 19, 1923, that I last saw him alive on Dec 18, 1923, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

" Aortic stenosis

10 mos. (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Prentiss, M. D.

, 19 (Address) 634 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — DATE OF BURIAL: Dec 22 '23

20 UNDERTAKER: Henry Hoeck Sun 1st, Eagle — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 81917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 81917

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 712 N. Spring St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Jones

(a) RESIDENCE. NO. 712 N. Spring ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Barney Jones

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 48 Months about. Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hou

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Martha Carter

(Address) 712 N. Spring St.

15 Filed DEC 20 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Dec 17, 1923, that I last saw h[illegible] alive on Dec 16, 1923, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Whitehead M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Dec. 20 1923
20 UNDERTAKER: Mrs. R. G. Elliott	ADDRESS, 1225 Ashland Ave

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lueticia

Spec. 1-10-21 M&T 1500 Bks.

D 81918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 81918

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 E. Madison St. 10 WARD)

2-FULL NAME Baby Harris

(a) RESIDENCE NO. 918 E. Madison St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Nov. 22 1923

7 AGE: Years | Months | Days: 25 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Edith Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Garland

14 Informant: Chas. Harris

(Address): 513 Madison St.

Filed DEC 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Dec 18th, 1923, that I last saw her alive on Dec 18th, 1923, and that death occurred, on the date stated above, at 10:20 a m.

The CAUSE OF DEATH* was as follows:

Acute pleuritis and pneumonia

following a tranquilization

of probably by measles

Contributory (Secondary) Probably of measles (duration) ..... yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) ..... Eisendall ....., M. D.

, 19 (Address) 1266 Edmondson Ave Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Dec 20 1923

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1726 Eastland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81919 | CERTIFICATE OF DEATH. | 100-061 81919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Appleton ST. 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur E. Jones

(a) RESIDENCE No. 1637 Appleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 24 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓			24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nothing

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Aston C Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ruth Disney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Aston C Jones
(Address) 1637 Appleton St

DEC 20 1923 ROBERT R. KRAUTER, Registrar
Date ..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1923, to Dec 19, 1923, that I last saw him alive on Dec 19, 1923, and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. H. Duvall, M. D.

12/19, 1923 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Lodge — DATE OF BURIAL Dec 20 1923

20 UNDERTAKER J. — ADDRESS Josiah Taylor 1400 N North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21 M&T 1500 Blks.

148 47 81920

HEALTH DEPARTMENT—CITY OF BALTIMORE

107-003 81920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. 9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Jackson

(a) RESIDENCE NO. 1802 Augusta St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 9 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Shayo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Wyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 20 1923 19 ROBERT B. KRAMER Registrar

Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923, to Dec 18, 1923.

that I last saw h.. alive on Dec 18, 1923,

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia due to respiratory obstruction (cause unknown)

Repeated attacks during life

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fatal Acute attacks

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Tracheotomy Date of 12-18-23

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Weech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 21st 1923

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 81921

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D 81921

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 38 S. Fulton Ave St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henderson Abbott

(a) Residence No. 38 S. Fulton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (~~write which~~ word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Amelia Abbott

6-DATE OF BIRTH (month, day and year) July 24, 1863

7-AGE. 60 yrs. 4 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contract Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Builder.

(c) Name of employer A. G. Lustberg

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Joseph Abbott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), North Car.

12-MAIDEN NAME OF MOTHER, Mary Newton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Julia Abbott

(Address) 38 S Fulton ave.

15- ROBERT R. KRAUSER, Registrar.

DEC 20 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1923 to Dec 20 1923.

that I last saw h~~im~~ alive on Dec 19 1923

and that death occurred, on the date stated above, at 5.40 ~~P.M.~~ A.M.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam,

(Signed) H. J. Hanna, M. D

. 19 (Address) 1822 N Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Dec 22 1923
20-UNDERTAKER,	ADDRESS
George J. Smith	1532 Hollins st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81922

CERTIFICATE OF DEATH.

129 D 81922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Etting ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lat Shaw

(a) RESIDENCE. No. 2013 Etting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Shaw

6 DATE OF BIRTH (month, day, and year) Oct 14-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

0886

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md

PARENTS

10 NAME OF FATHER Peter Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hager Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Preston

(Address) Laurens & Monroe Sts

Filed DEC 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1923, to Dec 18, 1923, that I last saw him alive on Dec 18, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chron. Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cystitis

(duration) — yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Chas. C. Conser, M. D.

12/19, 1923 (Address) 1101 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Auburn Cem.	12-21 1923
20 UNDERTAKER George J. A. Gibson	ADDRESS 1735 Edmondson Ave

N. B.—MAKE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81923

CERTIFICATE OF DEATH.

129 D 81923

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Bentley

(a) RESIDENCE No. 1307 H. Alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (40

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frisby Bentley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address) .....

15 DEC 20 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 1, 1923, to December 17, 1923, that I last saw him alive on December 16, 1923, and that death occurred, on the date stated above, at 1:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude A. Lenz, M. D.

12-17-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. M. Cemetery

DATE OF BURIAL 12/20 1923

20 UNDERTAKER Robert Kelly

ADDRESS 1511 Madeira St

Spec.—1-10-21—M&T—1500 Bks.

Pflaging

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81924

CERTIFICATE OF DEATH.

129 D 81924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 850 W Fayette ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth I Pflaging

(a) RESIDENCE NO. 850 W Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Fredk J Pflaging

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Schelling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Catherine Flaging 850 W Fayette st

15 Filed DEC 20 1923 ROBERT H. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18/1923

17 I HEREBY CERTIFY, That I attended deceased from 10/21/23, to 12/18/23, that I last saw h... alive on 12/18/23, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (Primary)

Chr. Inter. Nephr.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard Fenny, M. D.

(Address) 850 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 12/20/23.

20 UNDERTAKER: Fred A Tinley

ADDRESS: Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81925

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

×65 D 81925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Schwartz

(a) RESIDENCE NO. Fullerton, (Balto. Co.) WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 14 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. County

PARENTS

10 NAME OF FATHER Herman Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Dietz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Herman Schwartz (Address) Fullerton Md.

15 Filed ROBERT R. KRAUTER, Burial Permit Clerk. DEC 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1923, to Dec 17, 1923, that I last saw her alive on Dec 17, 1923, and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) J. T. T. Hundley, Jr., M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michael's Cemetery	Dec 21 1923
20 UNDERTAKER	ADDRESS
Fred'k Lissau & Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81926

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-002

D 81926

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4234 Reisterstown Road St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dimling

(a) Residence No. 4234 Reisterstown Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna K. Dimling

6-DATE OF BIRTH (month, day and year) Nov. 26, 1865

7-AGE. 58 yrs. 1 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Dimling

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katharine Weimar

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Anna K. Dimling
(Address) 4134 Reisterstown Road

15- DEC 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

Dr. Gay 1014 St Paul St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 19/23

17- I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1923 to Dec. 19, 1923 that I last saw him alive on Dec. 18, 1923 and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Anasarca

(Duration) 1 yr. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Removal of gland from the neck.

(Signed) Leslie M. Gay, M. D

, 19 (Address) 1014 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cemetery

DATE OF BURIAL, Dec. 21, 1923

20-UNDERTAKER, N. Vander & Sons

ADDRESS 1710 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81927 129 D 81927

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2218 Eutaw Place St., WARD)

2-FULL NAME Isaac Leopold

(a) RESIDENCE NO. 2218 Eutaw Place St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa H. Leopold

6 DATE OF BIRTH (month, day, and year) 1861 Nov 18

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Leopold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Whiteh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eugene Leopold
(Address) 200 W Lafayette Ave

15 Filed DEC 20 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19/1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1912 to Dec 19th, 1923 that I last saw h[illegible] alive on Dec 19th, 1923 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Leopold, M. D.

, 19 (Address) 200 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Shalom Cem	12/21/1923
20 UNDERTAKER David Londheim	ADDRESS 1820 Mt. Royal

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 81928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81928

CERTIFICATE OF DEATH.

185 23

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

2-FULL NAME Mino Pasuk.

(a) RESIDENCE NO. 131 W. Hamburg St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ---mos.--- ds. How long in U. S., If of foreign birth? 9 yrs. ---mos.--- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Lewis Olsen.
(Address) 129 W. Hamburg St.

15 Filed Robert P. Harrison, Registrar

C 20 1923 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 11, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Intra craneal hemorrhage due to a probable accidental fall while intoxicated.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute congestion of Kidney

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Dec, 19, 1923 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? 131 W. Hamburg St. Dec, 11, 1923.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DEC 20 1923 DATE OF BURIAL 192

20 UNDERTAKER ADDRESS

Commissioner Health

Bal. Wm. E. W22341

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81929

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N Carrollton Ave ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Byrd Page Harrison

(a) RESIDENCE. No. 222 N Carrollton Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sussex Co Va

PARENTS

10 NAME OF FATHER Henry H. Harrison

11 BIRTHPLACE OF FATHER (city or town) Berkeley (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Byrd Page

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pa

14 Informant Mrs Robert Randolph Boyce (Address) Richmond Va

DEC 26 1923 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 18 1923

17

I HEREBY CERTIFY, That I attended deceased from September, 1920, to December 18, 1923, that I last saw him alive on December 18, 1923, and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Respiro-Cardiac Paralysis

(Embolis into Cerebral vessels.)

(duration) yrs. mos. 1 dy

CONTRIBUTORY (Secondary) Arteria sclerosis & Chronic Interstitial Nephritis (duration) 3 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. W. Linton Clift, M. D.

Dec 19. 1923 (Address) 1312 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila Pa	Dec 21 1923
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W Fayette St

AFFIDAVIT REQUIRED. Every item must be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WHERE PERMIT WITH UNDERTAKER—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated in plain terms, so that it may be proper CAUSE OF DEATH

Spec.—1-10-21—M&T 1500 Bks.

D 81930

HEALTH DEPARTMENT—CITY OF BALTIMORE

167-001 ✓

D 81930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST. 9-1-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Amelia Spence.

(a) RESIDENCE NO. 913 S. Linwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				2 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Kenneth Spence

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Sinclair

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant
(Address)

15 Filed DEC 20 1923, 19 Robert E. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec 14, 1923, that I last saw him alive on Dec 14, 1923 and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E E Duncan, M. D.

12/14 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL DEC 20 1923

20 UNDERTAKER — ADDRESS

Commissioner Health, DEC 20 1923

Per. Wm. E. WOODALL

DEC 20 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of importance should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81931

D 81931

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 16 WARD)

2-FULL NAME Baby of Mildred Jordan

(a) RESIDENCE NO. 67 Biggs Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day 10 hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Md

PARENTS

10 NAME OF FATHER Harmelia Jordan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Rogers

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Johns Hopkins Hospital.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 20 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1923, to Dec 17 1923.

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

congenital atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan M'd D.

12/18 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	DEC 20 1923
20 UNDERTAKER Per. Wm. E. WOODALL	ADDRESS

DEC 20 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81932

D 81932

162

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. University Hospital ST. ..... WARD)

2-FULL NAME Baby Hughes

(a) RESIDENCE NO. Harmons Md ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Hughes

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mabel Martin

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Mother
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 20 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1923 to Dec 19, 1923.

that I last saw he alive on Dec 19, 1923,

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thomas Reese, M. D.

12/19, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 20 1923, 19
20 UNDERTAKER Commissioner Health, per Wm. E. WOODALL	ADDRESS -

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 81933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

197 D 81933

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Green

(a) RESIDENCE NO. 521 Walnut alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Erick Green

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Green

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Erick Green
(Address) 1102 Wagon Alley

15 Filed ....., 192 .....
Robert F. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopay or ~~inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy or ~~inquiry~~) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ballet wound in brain & Chest.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shotty, Robt McAuley a Brother

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Samuel, M. D.
(Coroner.)

12-20 1923 (Address) 1117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Dec. 21 1923
20 UNDERTAKER	ADDRESS
Brown & Freeland	1141 Schroder

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81934

D 81934

CERTIFICATE OF DEATH.

31

4

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lelar Cromwell

(a) RESIDENCE No. 685 W. Mulberry st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Lunchroom

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Geo. Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Alice Slade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) M.T.H.

15 Robert P. Harrison,

..... 19 ..... Registrar

Burial Permit Clerk.

C 201923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19 1923, to Dec. 18 1923,

that I last saw her alive on Dec. 18 1923,

and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L.L. Kelly, M. D.

12-18-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec 19 23

20 UNDERTAKER R C Gross

ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Copy to be furnished for information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81935

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-08 ✓ D 81935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clagett Marshall

(a) RESIDENCE NO. 2421 E. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the~~ word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Clagett L. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Hannah Pack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Clagett Marshall
(Address) 2421 E. Preston

15 Filed ..... 19 .....
Registrar

DEC 20 1923

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/23 .1923. to 12/20 .1923.
that I last saw h[illegible] alive on 12/20 .1923.
and that death occurred, on the date stated above, at 3:15 a. m.
The CAUSE OF DEATH* was as follows:

Acute Leukemia
(Myeloid Type)
(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical & Pathological & autopsy
(Signed) Isidore S. Jay M. D.
Dec. 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Cem	Dec 24, 1923
20 UNDERTAKER	ADDRESS
Wm Leask & Co. E	Mount

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY matter of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81936

CERTIFICATE OF DEATH.

D 81936

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp ST., WARD)

2-FULL NAME Mary Bowers

(a) RESIDENCE NO. 105 E Saratoga ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (~~write the~~ word)
Female	white	widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ (or) ~~WIFE~~ of widow

6 DATE OF BIRTH (month, ~~day, and year~~) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or.....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Wm Moller

(Address) 519 E. 30th St.

Filed DEC 20 1923, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-1923

17

I HEREBY CERTIFY, That I attended deceased from 11-17, 1923, to 11-20, 1923,

that I last saw her alive on 11-20-23 19.....,

and that death occurred, on the date stated above, at 5 45 Am.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Primary, Secondary, Contributory)

Myocarditis, Endocarditis ?

(duration) yrs. 2 ? mos ..... ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo Dampeer, M. D.

, 19 (Address) Md Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Dec 22, 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Monument

(1)—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Stomach - viscera + trachea

Spec.—1-10-21—M&T—1500 Bks.

(Marshall Smith)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81937 — CERTIFICATE OF DEATH. — X 65 — D 81937

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. ... ST., 9 WARD)

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marshal Smith

(a) RESIDENCE NO. Catonsville Md ST., ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records

DEC 20 1923 .19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Dec 18, 1923,

that I last saw ... alive on Dec 18, 1923,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Blood etc.

(Signed) J. H. Richmond, M. D.

, 19.. (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Locust Chapel Cem.

DATE OF BURIAL: Dec. 21 1923

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

G.S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 81938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 81938

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3314 Chestnut Ave (St.) 13 (Ward)

2-FULL NAME Andrew J. Taylor

(a) RESIDENCE No. 3314 Chestnut Ave (St.) 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Taylor

6 DATE OF BIRTH (month, day, and year): Feb 18 1856

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
67	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police 061

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired 12 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rachael ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Arthur F. Mathias

(Address) 3314 Chestnut Ave.

15 Filed Dec 20 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22 1923 to Dec 19 1923,

that I last saw him alive on Dec 19 1923,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

with dilatation

Arteriosclerosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cerebral anemia

Aphasia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs and general symptoms.

(Signed) C B Nonnemacher, M. D.

12.20. 1923 (Address) 3543 Chelsea Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden)

DATE OF BURIAL: Dec. 21 1923

20 UNDERTAKER: Horace H. Burgee

ADDRESS 363 Fallsroad

FOR B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 201923

Spec.—1-10-21—M&T—1500 Bks.

D 81939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 D 81939

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 N. Bond ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Warneman

(a) RESIDENCE NO. 1603 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F. H. Warneman

6 DATE OF BIRTH (month, day, and year) Oct-8-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Jos A. Bouchet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm F. H. Warneman

(Address) 1603 N. Bond St.

15 Filed DEC 20 1923, 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 3, 1923, to Dec 18, 1923.

that I last saw her alive on Dec 18, 1923,

and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

R Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? 1603 N Bond St

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. O. Carman, M. D.

12-19-1923 (Address) 1705 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	12/22 1923
20 UNDERTAKER	ADDRESS
Chas. F. Kraus & Son	118 W. Mt. Royal ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81940

CERTIFICATE OF DEATH.

118-092 ✓ D 81940

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital John ST. 17 WARD)

2-FULL NAME Virginia O'Connor

(a) RESIDENCE NO. 709 N. Fremont Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene A'Connor.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Wilhelm

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Louise Webb

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs. John Wilhelm (sister-in-law) (Address) 3204 Powhatan Ave.

15 DEC 20 1923 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1923, to Dec. 20, 1923, that I last saw her alive on Dec 20, 1923, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction due to incarceration of bowel in abdominal hernia - Shock following operation to relieve obstruction

(duration) of obstruction yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic cardiac disease

(duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death? 709 N. Fremont Ave.

Did an operation precede death? yes Date of Dec 20, 1923

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) H. T. Hoff M. D.

Dec 20 1923 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL DEC 22 1923

20 UNDERTAKER Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 81941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81941

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Bruns St ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard S. Johnson

(a) RESIDENCE NO. 503 Bruns St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie C Johnson

6 DATE OF BIRTH (month, day, and year) Oct. 24 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sample Carrier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Annie C. Johnson
(Address) 503 Bruns St

15 Filed DEC 21 1923, 192 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

(Signed) Robt. H. Flemming M. D. (Coroner.)

Dec 19, 1923 (Address) 888 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cem

DATE OF BURIAL 12-21 1923

20 UNDERTAKER David Fanlon

ADDRESS 916 Penna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81942

1-PLACE OF DEATH

REGISTERED NO. D 81942

CITY OF BALTIMORE: (No. 406 Lewis St ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Williams

(a) RESIDENCE No 406 Lewis St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Buddy Isaacs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Williams
(Address) 406 Lewis St

15 DEC 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probable Internal Abdominal Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

(Signed) J. S. Potter, M. D.
(Coroner.)

Dec 19/23. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	dec 22 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81943

CERTIFICATE OF DEATH.

66 D 81943

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 E Lombard ST., 1 WARD)

2-FULL NAME Simon Snyder

(a) RESIDENCE NO. 2120 Ed Lombard ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Snyder

6 DATE OF BIRTH (month, day, and year) July 7 1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yale Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis E Snyder
(Address) Cumberland Md

15 DEC 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. or over mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

(Signed) Thos B. Norton M. D.
(Coroner)

Dec 20 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Evergreen Cem	Dec 24 1923

20 UNDERTAKER Last ADDRESS Keyser 1439 E Lea

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81944

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 81944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2036 E. Fairmount St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DORA M. BROWN

(a) Residence No. 2036 E. Fairmount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Brown

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 53 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Chaae Fogal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Lewenstein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto St

DEC 21 1923

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-20-23

17- I HEREBY CERTIFY, That I attended deceased from Dec-18 1923 to Dec-20 1923

that I last saw her alive on Dec-20 1923,

and that death occurred, on the date stated above, at 11-05 m.

The CAUSE OF DEATH* was as follows:

(Cerebral hemorrhage)

Chronic Cardio-vascular disease

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? — Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Herman Seidel M. D.

, 19 (Address) 2404 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mahrem Memorial	12-21 1923
20-UNDERTAKER	ADDRESS
Jack Lewis 1439	E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81945

CERTIFICATE OF DEATH.

74 00 D 81945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Schiller

(a) RESIDENCE NO. 115 N. Pine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Schiller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1739 E. Balto.

15 DEC 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1923 to Dec 21, 1923, that I last saw him alive on Dec. 21, 1923, and that death occurred, on the date stated above, at 7:25A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, myocardial & cerebral (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isidor L. Levy, M. D.

Dec. 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rondals	Dec 24 1923
20 UNDERTAKER	ADDRESS
Jos. Lewis	1739 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81946

CERTIFICATE OF DEATH.

D 81946

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 Keyworth av ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses C. Weinman

(Residence in Baltimore: No. 2524 Keyworth av St.; ....yrs., ...mos. ....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired merchant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Benjamin Weinman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Esther Leal

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto.

15-

DEC 21 1923 ..... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1923, to Dec 20 1923, that I saw him alive on Dec 20 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of liver

.....

.....

..... (Duration) ....1....yrs. ....mos. ....ds.

CONTRIBUTORY. Exhaustion Multiple
(Secondary) Emboli & Roseola.

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Joseph E. Gichner M. D.

Dec 20, 1923 (Address) 1506 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Nat. Carmel

DATE OF BURIAL, Dec 21 1923

20-UNDERTAKER Last Lewis

ADDRESS 1439 E. Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D 81947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1794 D 81947

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 405 N. Fremont ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeremiah Burton

(Residence in Baltimore: No. 405 N Fremont St.; 43 yrs. 7 mos. 29 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, April 21, 1880 (Month) (Day) (Year)

7-AGE, 43 yrs. 7 mos. 29 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Levi L Burton

11-BIRTHPLACE OF FATHER (State or Country): Onancock Va

12-MAIDEN NAME OF MOTHER: Mary Jane Fogus

13-BIRTHPLACE OF MOTHER (State or Country): Onancock Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mary Burton

(Address): 405 Fremont ave

15- DEC 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 20, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 1923, to Dec 20 1923, that I saw h[illegible] alive on Dec 19 1923, and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary) Time

(Duration) yrs. mos. da.

(Signed) William H Wright, M. D.

Dec 20, 1923 (Address) 209 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pt Lookout — DATE OF BURIAL, DEC 22, 1923

20-UNDERTAKER Sam'l H. Case Co. — ADDRESS 1250 Druid

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81948

CERTIFICATE OF DEATH.

100-001 D 81948

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

2-FULL NAME John Ackerman

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

DEC 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 30, 1923, to December 19 1923, that I last saw h im alive on December 18, 1923, and that death occurred, on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (Terminal) (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Lab .....

(Signed) Claude Q. Hoag, M. D.

12-22-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	12-21 1923
20 UNDERTAKER	ADDRESS
Ernest Hartle	114 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

U.S. A. F. ETY

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81949

100-001

D 81949

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 N Gay ST., 8 WARD)

2-FULL NAME Anna B Lilly

(a) RESIDENCE NO. 1904 N Gay ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm A Lilly

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE: Years 61; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: Ind

9 BIRTHPLACE (city or town) (State or country): Ind

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): W. A. Lilly 1904 N Gay

15 DEC 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1923, to Dec 19, 1923, that I last saw her alive on Dec 19, 1923, and that death occurred, on the date stated above, at 11 30P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec 22, 1923

20 UNDERTAKER: Robt J Johnson

ADDRESS: 1402 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY

Spec.—3-10-21—M&T—1500 Bks.

D 81950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/D 81950

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Konstance Vakoutis (Vakonlas)

(a) RESIDENCE NO. 313 S. Bond st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Vakonlas (Vakoutis)

6 DATE OF BIRTH (month, day, and year) 1893 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Contanino Raciolas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Catherine Mariconas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records

(Address) M.T.H.

15 DEC 21 1923 Burial Permit Clerk, Registrar

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to Dec. 20, 1923, that I last saw her alive on Dec. 20, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho- Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A Lally, M. D.

12-20-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Dec	21 1923
20 UNDERTAKER	ADDRESS
John H. Weber	1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81951

CERTIFICATE OF DEATH.

118-00

D 81951

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Bell Gen Hosp ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Hussey

(a) RESIDENCE NO. 1113 N Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Wyatt Hussey

6 DATE OF BIRTH (month, day, and year) June 15, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wyatt Hussey

(Address) 1113 N Gay St

15 Filed DEC 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 31 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 20 19 23 to December 31 19 23

that I last saw h alive on December 21 19 23

and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Structure of Rectum

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Hamm, M. D.

19 (Address) 4704 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harper Hosp

DATE OF BURIAL Dec 22, 1923

20 UNDERTAKER Wm Ecroyd Son & Donnelly

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81952

CERTIFICATE OF DEATH.

100-001

D 81952

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 W 26th St. 12 WARD)

2-FULL NAME Rosa Marie Dorter.

(a) RESIDENCE No. 419 W 26th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17/1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
X			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jesse D Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Fannie Soles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Jesse D Carter (Address) 419 W 26th St

15 Filed DEC 21 1923 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17 1923, to Dec 20, 1923, that I last saw h W alive on Dec 20, 1923 and that death occurred, on the date stated above, at 8 30P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) W

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Calhoun Dorsey, M. D.

Dec 27, 1923 (Address) 3821 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hum[illegible] DATE OF BURIAL: Dec 21 1923

20 UNDERTAKER: C HENOWETH & SON, ADDRESS: 1637 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Blks.

D 81953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81953

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Lafayette Ave. W. WARD)

2-FULL NAME Benj Mathews

(a) RESIDENCE NO. 617 Lafayette Ave W. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedoring

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wilborn Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Angeline Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wilborn Jones
(Address) 1809 Argyle Ave

15 DEC 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25th, 1923, to Dec 18th 1923.

that I last saw him alive on Dec. 18th, 1923

and that death occurred on the date stated above, at 9'30 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hard work & Worry

Coughing (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Fen Ellis, M. D.

19 (Address) 52 Pierpont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Dec. 21 1923

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81954 74-09½ 81954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Glover ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L Magar

(a) RESIDENCE No. 583 N. Glover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George A. Magar

6 DATE OF BIRTH (month, day, and year) Nov 19-1862

7 AGE : Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Kramer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Swartz

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant George A. Magar (Address) 523 N. Glover St

15 DEC 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-18-23 19

17 I HEREBY CERTIFY, That I attended deceased from 12-16-23 19 ..... to 12-18-23, that I last saw her alive on 12-17-23, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Frederick J Bierman M. D.

(Address) 1919 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Dec 22 1923

20 UNDERTAKER Wm C. Miller ADDRESS 2338 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81955

CERTIFICATE OF DEATH.

D 81955

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1119 Druid Hill Ave. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mozzie Ward

(Residence in Baltimore: No. 1119 Druid Hill Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: about (Month) (Day) 1897 (Year)

7-AGE: 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country): Unknown.

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Richardson

(Address) 1119 Druid Hill Ave

15- DEC 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 18, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a. Dilatation of Heart.

probably Immediate

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) a. Gastro Enteritis

over

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Dec. 21, 1923 (Address) 2802 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 12/21/1923

20-UNDERTAKER. ADDRESS

Samuel T. Hensley 1119 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81956

CERTIFICATE OF DEATH.

154-601 ✓ D 81956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hosp St. ..... WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Jones

(a) RESIDENCE NO. 101 S Caton St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Howard L. Jones

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary V. Bach

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Andrew Bach
(Address) 101 S. Catherine St

15 Filed DEC 21 1923, 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec 20, 1923, that I last saw h[illegible] alive on Dec 20, 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Interval Hydrocephalus

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure Forceps.

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

(Address) Md Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Md.	Dec 24 1923
20 UNDERTAKER Harry W. Witzke	ADDRESS 1531 W. Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital.

Spec.—1-10-21—M&T—1500 Pds.

D 81957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-99

D 81957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. John P. Cassin (Helen)

(a) RESIDENCE NO. 254 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John P. Cassin

6 DATE OF BIRTH (month, day, and year) June 15 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alfred W. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nancy Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Marie Caskey

(Address) 234 Robert St - Baltimore

Filed DEC 21 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1923, to Dec. 20, 1923, that I last saw her alive on Dec. 20, 1923, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 22 1923

20 UNDERTAKER Harry H. Fritz & Co — ADDRESS 1531 W. Lombard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

1836 8

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81958

CERTIFICATE OF DEATH.

x 84 D 81958

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ora Kline

(a) RESIDENCE NO. Deerfield, N Y ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of W. E. Kline

6 DATE OF BIRTH (month, day, and year) 1869.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Charles Eglebright

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Louis Ham.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Y

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 21 1923 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1923, to Dec 20, 1923, that I last saw her alive on Dec 20, 1923, and that death occurred, on the date stated above, at 4 55 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N.Y. State

Did an operation precede death? Yes Date of Dec 17-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam.

(Signed) Warfield M. Frost, M. D.

12/21, 1923 (Address) J H Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain Dale N Y — DATE OF BURIAL Dec 21 1923

20 UNDERTAKER Joseph Abrams — ADDRESS 221 N Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Benign

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81959

D 81959

CERTIFICATE OF DEATH.

91-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Anderson

(a) Residence No. Preston & Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, Widowed, ~~or Divorced,~~ Widow (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Anderson

6-DATE OF BIRTH (month, day and year) 1851

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS

10-NAME OF FATHER, Christopher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary Comerford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Sister Florence

(Address) Preston & Valley

15- Robert P. Harrison Registrar.

DEC 21 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/20/23

17- I HEREBY CERTIFY, That I attended deceased from 12-7, 1923, to 12-20, 1923

that I last saw h.e alive on 12-19, 1923

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Leonard Wirts M. D

12/21, 1923 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents DATE OF BURIAL. Dec 22, 1923

20-UNDERTAKER, H. C. Wiedefeld ADDRESS 914 Greenmt Ave

IMPORTANT—THIS CERTIFICATE, WITH UNDERTAKER'S RETURN, MUST BE RETURNED EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important, in plain terms, so that it may be properly classified. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EC 211923

B 81960

HEALTH DEPARTMENT--CITY OF BALTIMORE

B 81960

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1504 Rutter St.; 1 WARD) REGISTERED No. C 4438

(If death occu... a hospital or insti... give its NAME insti... street and numb... fill out No. 18.)

2 FULL NAME Ethel Washington

(Residence in Baltimore: No. 1504 Rutter St.; 2 yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: November, 1890 (Month) (Day) (Year)

7 AGE: 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9 BIRTHPLACE (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Washington

(Address) 1504 Rutter St

15 Robert P. Harrison, 191 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 19 (Day) 23, 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased
Dec 17, 1923 to Dec 19 23 19
that I saw her alive on Dec 19 23 19
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Hypostasis - Cerebral Hemorrhage

(Duration) yrs. 3 mos.

Contributory (SECONDARY) Arteriosclerosis

(Duration) yrs. mos.

(Signed) T. S. Hunkins

Dec 20, 1923 (Address) 1202 Druid Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT C... state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICID... HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS... OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Washington D.C. DATE OF BURIAL 12 27 19

20 UNDERTAKER: Samuel Hawkins ADDRESS Middle

Spec.—1-10-21—M&T—1500 Bks.

D 81961

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 81961

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 N. Central Ave ST., 9 WARD)

2-FULL NAME Annie E. Casey

(a) RESIDENCE NO. 1327 N. Central ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Casey

6 DATE OF BIRTH (month, day, and year) Jan 9th 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Clisham.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Cathrine McCormick

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland.

14 Informant (Address) Jas. Casey 1327 N. Central Ave

15 ..... 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

DEC 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1923, to Dec 18, 1923, that I last saw her alive on Dec. 18, 1923, and that death occurred on the date stated above, at 11.57 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Benj. D. Hayden, M. D.

12/24 1923 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Dec. 22 1923

20 UNDERTAKER John A. Inman — ADDRESS 3000 E. Balto St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 81962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81962

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Elsinore Av ST., 15 WARD)

2-FULL NAME Clara Taylor

(a) RESIDENCE NO. 2509 Elsinore Av ST., 15 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? 80 yrs. 3 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: (none)

6 DATE OF BIRTH (month, day, and year): Aug-28-1843

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Charles R. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Maryland

12 MAIDEN NAME OF MOTHER: Georgianna Millemon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Young A Wilson (niece)
(Address) 2509 Elsinore Ave.

15 Filed DEC 21 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to 12-21, 1923, that I last saw her alive on 12-20, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Femoral Artery Sclerosis: Amputation - Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility - Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter R Schampeck, M. D.

(Address) 806 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns P.E. (Waverly) Family — DATE OF BURIAL: Dec 23 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOOLEN, Successor) — ADDRESS: 103 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81963

CERTIFICATE OF DEATH.

X 100-001

D 81963

1-PLACE OF DEATH Church Home and Inf

CITY OF BALTIMORE: (No. 6 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE No. Petersburg W Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. day ds. How long in U. S., if of foreign birth? 12 days mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Smith

6 DATE OF BIRTH (month, day, and year): June 22 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Petersburg W Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Petersburg W Va

14 Informant: Chas T. Smyth

(Address) Petersburg W Va

15 Date: DEC 21 1923, 19

Registrar: Robert B. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21, 19 23

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 19 23, to Dec 21, 19 23;

that I last saw h alive on Dec 21, 19 23;

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Ulcer, Gastric

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 16 '23

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical

(Signed) Gay Hunt Pamelton, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg W. Va — DATE OF BURIAL: 12/21 1923

20 UNDERTAKER: Albert L Hiltz Jr — ADDRESS: 1606 N Chester St

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81964

CERTIFICATE OF DEATH.

15 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3032 Presstman Street St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Landon

(a) Residence No. 3032 Presstman Street St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas F. Landon

6-DATE OF BIRTH (month, day and year) April 20, 1853

7-AGE. 70 yrs. 7 mos. 29 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Thomas W. Conner

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rebecca Hooper

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Maryland

14- (Informant) Mrs. M. E. Landaner

(Address) 3210 Waterook Ave.

15- Robert F. Harrison,
Filed ..... 192 ..... Registrar.

Burial Permit Clerk.

DEC 7 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to Dec 19, 1923, that I last saw her alive on Dec 18, 1923, and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Aortic was Mitral
regurgitation

(Duration) yrs. 6 mos. 13 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 4 da.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Herbert E. Bapp, M. D.

12-19, 1923 (Address) 2043 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem	Dec. 22, 1923
20-UNDERTAKER, Karl B. Brook	ADDRESS 1003 N Dallas

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81965

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 113 White Avenue (Hamilton 27 St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Annie Hebrank

(a) Residence No..... 113 White Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Hebrank

6-DATE OF BIRTH (month, day and year) April 17, 1838

7-AGE, 85 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Tannheimer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Mr. Andrew E. Smith

(Address) 119 East White Ave.

15- Robert P. Harrison,

....., 192.... Registrar.

DEC 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 27, 1923, to December 20, 1923, that I last saw her alive on December 17, 1923, and that death occurred, on the date stated above, at 12.55 noon m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Infirmities of age

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

12-20 1923 (Address) Harford Rd. & Altoona Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Dec 22, 1923
20-UNDERTAKER. Joseph L. Cook	ADDRESS 1003 N. Gilmor St.

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Turner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81966

D 81966

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 W Fayette ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter B Turner

(a) RESIDENCE NO. 2314 W Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Turner

6 DATE OF BIRTH (month, day, and year): Apr 18-1839

7 AGE: Years 84 | Months 7 | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): Retired Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas H Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Morgonett Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Walter S Turner

(Address): 2314 W Fayette St

15 Filed: DEC 21 1923 Robert F. Duffy Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Dec 29, 1923.

that I last saw him alive on Dec 27, 1923.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): cardiac insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Hall, M. D.

, 19 (Address) Walbrook

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec 22 1923

20 UNDERTAKER: George. Schwab — ADDRESS: 1101 Edmondson Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

81967

CERTIFICATE OF DEATH.

11-007 D 81967

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2705 Parkwood Ave (ST.) (13 WARD)

2-FULL NAME Lucy Jane Rubble

(a) RESIDENCE NO. 2705 Parkwood Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Andrew Rubble

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Roanoke
(State or country) Va

PARENTS

10 NAME OF FATHER Seaton Campbell

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. Theodore C. Rubble
(Address) Sykesville Md.

15 Filed DEC 27 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 '23 19.... to Dec 20 '23 19....
that I last saw her alive on Dec 20 '23 19....,
and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Uremia) (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial (duration) yrs. 4 mos ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry B Stoll M. D.

(Address) 120 S High

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec. 22 1923
20 UNDERTAKER	ADDRESS
Wm Fickus & Sons	North & Pa

F.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be plain terms, so that it CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 31968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81968

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (NO. 1112 N. Mount ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malcolm Hasson

(a) RESIDENCE NO. 2445 E. East Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) June 2 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltr., Md.

PARENTS

10 NAME OF FATHER Malcolm Hasson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltr, Md

12 MAIDEN NAME OF MOTHER Ellen Sweeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltr., Md

14 Informant Mrs Addie Moore (Address) 2421 Monument Ave.

15 Filed DEC 21 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/21 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/12, 1923, to 12/21, 1923 that I last saw him alive on 12/21, 1923, and that death occurred, on the date stated above, at 1.35 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma involving abdominal viscera and left lung ? - approx. 1 yr (duration) ? yrs. ? mos.

CONTRIBUTORY (Secondary) Toxemia (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) A. A. Lussenhop, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 12/22 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 920 Argyle Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bell

(a) Residence No. 920 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of L

6-DATE OF BIRTH (month, day and year) Unk 1871

7-AGE,	If LESS than 1 day,
51 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 51

(c) Name of employer 0

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Cyrus Harden

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Rosetta

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Bertie Proctor

(Address) 920 Argyle Ave

15- Filed DEC 22 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 20-1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 18, 1923 to Dec 20, 1923

that I last saw her alive on Dec 19, 1923

and that death occurred, on the date stated above, at 1.25 am.

The CAUSE OF DEATH* was as follows:

Paralysis. Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation Symptoms

(Signed) H. Finney M. D.

Dec 21, 1923 (Address) 718 Park Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Asbury	Dec 22 1923
20-UNDERTAKER. John H Fowler	ADDRESS 842 Lexington St

DEC 22 1923

FILL—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

B 81970

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 81970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Louise H Lion

(a) RESIDENCE NO. 2523 Brookfield ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER John Lion
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga
12 MAIDEN NAME OF MOTHER Ada Myers
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19.... Robert P. Harrison, Registrar

DEC 22 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1923

17
I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923, to Dec 21, 1923,
that I last saw her alive on Dec 21, 1923
and that death occurred, on the date stated above, at 6 10 P m.
The CAUSE OF DEATH* was as follows:
Brain tumor – right cerebral – rt. temporal cystic glioma
(duration) 5 yrs. ..... mos ..... ds.
CONTRIBUTORY (Secondary) —— (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of June 21 1919 Dec 10 1923
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) F Cy Reichert, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew — DATE OF BURIAL Dec 22 23

20 UNDERTAKER J Ahrens & Co — ADDRESS 1611 Mad ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant

Cor.—1-12-23—M&T—100 Bks.

D 81971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81971

CERTIFICATE OF DEATH.

100-001

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3100 Fait ave ST., 1 WARD)

2-FULL NAME Julia May Spangler

(a) RESIDENCE NO. 3100 Fait ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) ~~Dec~~ July 28th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. W. Spangler Jr

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Etzel

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Chas W. Spangler Jr
(Address) 3100 Fait ave

15 Dec 22 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

EC 221923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(Duration) 4 yrs. 4 mos. 2 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Norton, M. D.
(Coroner)

Dec 19th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Balto. Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL Dec 22 1923

20 UNDERTAKER Lilly & Feiler

ADDRESS 403 S. Mt. Ave

mation should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it r
TION is very important. See instructions on b

Spec.—1-10-21—M&T—1500 Bks.

D 81972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 81972

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 1 WARD)

2-FULL NAME Margaret M. Schirmer.

(a) RESIDENCE NO. 7876 O'Donnell St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Schirmer.

6 DATE OF BIRTH (month, day, and year) Aug. 14-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George Ruley

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Edward J. Schirmer (Husband)

(Address) 7876 O'Donnell St

15 Filed DEC 27 1923, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 6, 1923, to Dec 20, 1923,

that I last saw her alive on Dec 19, 1923,

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis, arthritis + Pneumonia (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alma B Leppman, M. D.

12/21, 1923 (Address) 718 N Collington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Dec 23 1923
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81973

CERTIFICATE OF DEATH.

74-23 B 81973

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 719 So. Broadway ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Vogt

(a) RESIDENCE NO. 719 So. Broadway ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Emma L. Vogt

6 DATE OF BIRTH (month, day, and year) Sept 22 1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Vogt

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna Borcherdin

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Emma L. Vogt
(Address) 719 So. Broadway

15 Filed DEC 22 1923, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo. A. Bryan, M. D.
(Coroner.)

Dec 20 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Dec 22 1923

20 UNDERTAKER Wm. C. Blaeke ADDRESS 927 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81974

CERTIFICATE OF DEATH.

46 D 81974

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1121 N. Fulton Ave St., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie May Parlett

(a) RESIDENCE NO. 1121 N. Fulton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 7-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Wm. A. Parlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriett Slaughter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Mrs. Samuel Billingsley (Address) 1121 N. Fulton Ave

15 Filed DEC 22 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1923, to Dec 21st, 1923, that I last saw her alive on Dec 20th, 1923, and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

About (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage due to Carcinoma

About (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of Dec 10th 1923

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) O. N. Duvall, M. D.

Dec 21, 1923 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemet	Dec 24 1923
20 UNDERTAKER	ADDRESS
Wm Cook	532 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Exactness in form of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81975

CERTIFICATE OF DEATH.

D 81975

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Strohl

(a) RESIDENCE No. 225 Slemmer Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Strohl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie Fatie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Hospital Records
(Address) M.T.H.

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

DEC 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27 1922, to Dec. 20, 1923, that I last saw him alive on Dec. 20, 1923, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Xray and Sputum

(Signed) L. A. Lally, M. D.

12-21-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Dec 23 1923
20 UNDERTAKER	ADDRESS
Johannah Landes	1004 Aisquith st

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 81976 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81976

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward) 123

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Flynn

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1851

7-AGE.	If LESS than 1 day.
72 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, James Flynn

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Irelznd

12-MAIDEN NAME OF MOTHER, Katherine Lyons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Record

(Address)

15- Filed ..... 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

DEC 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from December 7, 1923 to December 18 1923

that I last saw him alive on December 18 1923

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cholecystitis & Cholelithiasis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 15-23

Was there an autopsy? No Relief of gall stones.

What test confirmed diagnosis? Clinical Findings

(Signed) Wm J Fulton M. D

12-19-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 22 1923
20-UNDERTAKER, Dom. Wm. E. WOODALL	ADDRESS

Dom. Wm. E. WOODALL, Undertaker, 1331 Bank St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 21 1923

Spec.—5-19-13—M. & T.—500 Bks.

D 81977

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901

D 81977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths' Home - Chesnut Hill ST.; 9 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Mayes

(Residence in Baltimore: No. St. Elizabeths' Home – Chesnut Hill Ave St.; ....yrs.,....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. negress

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.)

6-DATE OF BIRTH. December (Month) 25 (Day), 1922 (Year)

7-AGE, ...yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Norbert Jackson

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Elsie Mayes

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison, Registrar.

Filed DEC 22 1923, 191....

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 15 1923, to December 19 1923, that I saw h er alive on December 19 1923, and that death occurred, on the date stated above, at 6.45 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)....yrs....mos. 4 ds.

CONTRIBUTORY (Secondary) ..... pan peumonia ende

(Duration)....yrs....mos....ds.

(Signed) Frank J. Ayd M. D.

Dec 20, 1923 (Address) 2045 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL | DATE OF BURIAL, DEC 22 1923

20-UNDERTAKER ADDRESS

Commissioner Health, DEC 22 1923

Per. Wm. H. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

D 81978 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 81978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 E. Biddle ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine F. Morris

(a) RESIDENCE NO. 1523 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 47 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, (or) WIFE of: Wm. Alfred J. Morris

6 DATE OF BIRTH (month, day, and year): June 21 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(h) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph Krastel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Catherine Brunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Wm. Alfred J. Morris 1523 E. Biddle

15 Filed DEC 22 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21 1923

17 I HEREBY CERTIFY, That I attended deceased from about 4 Nov 20 to Dec 20 1923, that I last saw h[illegible] alive on Dec 20, 1923, and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Duration, about 1 year

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? nr

Did an operation precede death? nr Date of .....

Was there an autopsy? nr

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Dec 1923 (Address) 1032 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Dec. 24 1923

20 UNDERTAKER: Henry Hoerth Son — ADDRESS: New Egypt

INK—THIS IS A PERMANENT RECORD. E[illegible] of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A TRUE COPY

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 81979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81979

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 W.Franklin ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A.Ridgely,

(a) RESIDENCE. No. 933 W.Franklin St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, ~~widowed, or divorced~~ (HUSBAND) of (or) WIFE of Cyrus W.Ridgely,

6 DATE OF BIRTH (month, day, and year) Feb.20.1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.Md.

PARENTS

10 NAME OF FATHER John Fishpaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.Md.

12 MAIDEN NAME OF MOTHER Rebecca Price,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.Md.

14 Informant (Address) Cyrus W.Ridgely, 933 W.Franklin St

15 Filed DEC 22 1923, 19... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.21.1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to Dec 21, 1923, that I last saw her alive on Dec 20, 1923, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Probable chronic Nephritis -

(duration) about 1 year yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Microscopic & Physical

What test confirmed diagnosis? Exam

(Signed) H E Kmith, M. D.

12/22, 1923 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Dec.24.1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date TION is very important. See instructions on back of certificates.

U.S.A. KODAK

Spec.—1-10-21—M&T—1500 Blks.

D 81980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81980

CERTIFICATE OF DEATH.

74-00

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 W. North Ave. St. 15 WARD)

2-FULL NAME Mrs. Anna Margaret Miedwig

(a) RESIDENCE No. 2800 W. North Ave. St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. X mos. X ds. How long in U. S., if of foreign birth? 38 yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of John Miedwig,

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	90	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John E. Miedwig.
(Address) 2800 W. North Ave.

15 Robert P. Harrison, 19 Burial Permit Clerk. Registrar

EC 221923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21" 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20" 1923. to Dec. 21" 1923.

that I last saw her alive on Dec. 21" 1923.

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No,

What test confirmed diagnosis? None- Have history of stroke.

(Signed) Dr. H. Hartman, M. D.

19 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec. 24 1923

20 UNDERTAKER Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

WARNING—THIS SPACE RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item under mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1509 Bks.

D 81981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 81981

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Mount Street ST., 19 WARD)

2-FULL NAME Joseph C. Burroughs.

(a) RESIDENCE NO. 120 S. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. - mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Teresa M. Burroughs

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	-	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Joseph C. Burroughs

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Mary Burroughs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Teresa M. Burroughs (Address) 120 S. Mount St.

15 Filed DEC 22 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1923 to Dec. 21, 1923.

that I last saw him alive on " 20 , 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (8 Mos.)

Tubercular Laryngitis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Caridac Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Coolahan, M. D.

12/21/23, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Dec 24 1923

20 UNDERTAKER Robert L Little

ADDRESS 1700 Edmondson Ave

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 81982 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 81982

CERTIFICATE OF DEATH.

1400

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 537 N. Wolfe ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Basil L. Smith

(a) RESIDENCE NO. 537 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Francis 6 Smith

6 DATE OF BIRTH (month, day, and year) Nov 7/53

7 AGE — Years: 70 — Months: 1 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 011

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER Geo. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Francis 6. Smith

(Address) 537 N. Wolfe

15 Filed ..... Robert P. Harrison, Registrar

DEC 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17

I HEREBY CERTIFY, That I attended deceased from ....., 1923, to Dec 20, 1923.

that I last saw h[illegible] alive on Dec 19 1923

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter N White, M. D.

12/21. 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec 22 1923

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Orleans

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec—12-23-21—E.B.R.S.—400 Bks.

D 81983 HEALTH DEPARTMENT—CITY OF BALTIMORE D 81983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1313 Pennsylvania St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Eliza Chase

(a) Residence No. 1313 Pennsylvania St., 17th Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 25 1847

7-AGE, 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.
10-NAME OF FATHER. Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown
12-MAIDEN NAME OF MOTHER. Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-(Informant) Robert Jones
(Address) 1313 Pennsylvania

15-Filed Dec 21 1923 Robert P. Harris Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 20 23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1923, to Dec 20, 1923, that I last saw h[illegible] alive on Dec 19, 1923, and that death occurred, on the dute stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Frank E. Wright, M. D.

Dec 20, 1923 (Address) 1716 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 12-22-1923
Mt Auburn	
20-UNDERTAKER. David Eastern	ADDRESS 916 Pa ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81984

188-003

D 81984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joshua P. Gains

(a) RESIDENCE No. 1616 Argyle Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Gains

6 DATE OF BIRTH (month, day, and year) about 1878 Gains

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Mrs. Minister 186

9 BIRTHPLACE (city or town) (State or country) Essex Co, Va. Dec. 21, 1923

PARENTS

10 NAME OF FATHER Albert Gains

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va,

12 MAIDEN NAME OF MOTHER Betty Wise,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Joseph Gains
(Address) 1711 Freeman Ave

15 DEC 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above. (Autopsy)

The CAUSE OF DEATH* was as follows:

Hemorrhage due to rupture of liver

(duration) yrs. 7 hrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessey, M. D.
(Coroner.)

Dec. 21, 1923 (Address) 211 Courtland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-27 1923
20 UNDERTAKER David Easton	ADDRESS 916 Pa Ave

P.S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 21 1923

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be stated EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81985

122 D 81985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 Washington ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Helmundai

(a) RESIDENCE NO. 2515 Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Francis Szuromska

(Address) 2515 Washington Ave

15 Filed ..... 19 ..... Robert F. Garrison, Registrar

DEC 22 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 20, 1923, that I last saw h[illegible] alive on Dec 20, 1923, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Phalangitis

(duration) - yrs. 8 mos. [illegible] ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) David L Strahan, M. D.

, 19 (Address) 328 Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem., DATE OF BURIAL Dec. 24 1923

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S Ann St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer---Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-alcoholic.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81986

D 81986

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Swift or Smith

(a) RESIDENCE NO. 1401 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) O'N

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York , Pa.

PARENTS

10 NAME OF FATHER Frank Swift or Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records. (Address)

Registrar Robert P. Harrison,

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 19 23

17 I HEREBY CERTIFY, That I attended deceased from December 18, 19 23, to December 20, 19 23, that I last saw h in alive on December 19, 19 23, and that death occurred, on the date stated above, at 5:15 A.M. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. (Est.) ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Bra—, M. D.

12-20-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 22 1923

Address

Buried Dec 22 1923

DEC 22 1923

DEC 21 1923

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Jolly)

D. 81987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 81987

CERTIFICATE OF DEATH.

5 44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 E Fayette ST., 5 WARD)

2-FULL NAME Carrie F. Jolly

(a) RESIDENCE NO. 1209 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Cd.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. W. Jolly

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. J. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Tilghman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Wm. W. Jolly

(Address)

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

DEC 22 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 6 1923, to Dec 21 1923, that I last saw h alive on Dec 21 1923, and that death occurred on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(Not Malignant)

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Exhaustion from Pulmonal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) ....., M. D.

, 19 (Address) 607 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemty — DATE OF BURIAL: 12/24/23

20 UNDERTAKER: George T. A. Gibson — ADDRESS: 1935 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 81988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-006 81988

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 801 S. Broadway ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Miskell.

(Residence in Baltimore: No. 807 S. Broadway St., Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day) 1849 (Year)

7-AGE, about 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Murphy

(Address) 807 S. Broadway

15- Robert P. Harris, M.D.

Filed....., 191..... Burial Permit Granted.

DEC 22 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 21st, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) Thos. B. Norton M. D.
(Coroner.)

Dec 21st, 191... (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Baltimore Md

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cem. DATE OF BURIAL, Dec 22, 19.2

20-UNDERTAKER Lilly & Geiler ADDRESS 4038. Wolfe

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Schoettle)

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-006 81989

D 81989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 332 E. 20th St. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Schoettle

(a) RESIDENCE. NO. 1701 N. Charles St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov-11-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto-Md.

PARENTS

10 NAME OF FATHER Carl Schoettle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Katherine Schaechaldt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. E. Trotter Address 332 E 20th St

15 Filed DEC 27 1923, 19 Robert P. Harris Registrar

Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec. 20, 1923, that I last saw him alive on Dec 17, 1923, and that death occurred, on the date stated above, at 8.15 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchitis (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart Chronic alcoholism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none except

(Signed) Edward Powell Mase M. D.

Dec 20 1923 (Address) 105 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Com.	Dec 24 1923
20 UNDERTAKER	ADDRESS
C. A. Weisfeld Jr	501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CIRCUMSTANCES may be important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81990

CERTIFICATE OF DEATH.

D 81990

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mark F. Gorman

(a) RESIDENCE NO. 423 E. [illegible] St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James Gorman

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Carl

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Hospital Record.
(Address)

15 DEC 22 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20/23 19

17 I HEREBY CERTIFY, That I attended deceased from 12/7/23, 19 ..., to 12/20/23, 19 ..., that I last saw h[illegible] alive on 12/20/23, 19 ..., and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastric)

7 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Dolley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Dec 24 1923
20 UNDERTAKER	ADDRESS
E. A. Wiedefeld &	601 E 22 St.

IN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81991

CERTIFICATE OF DEATH.

100-001 ✓ D 81991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Gilmore ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earnestine Holt.

(a) RESIDENCE No. 220 N. Gilmore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Francis Holt.

11 BIRTHPLACE OF FATHER (city or town) St Marys Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Estine Mister

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Robert Stewart. (Address) 220 Gilmore St.

15 DEC 22 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-21- , 193 , to 12-22 , 1923 , that I last saw him alive on 12-21 , 1923 , and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? examination

(Signed) Frank J Saunders M. D.

12-23 1923 (Address) 1123 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	DEC 25 1923
20 UNDERTAKER	ADDRESS
Jas. W. Case Sons	1400 Madison

Spec—12-23-21—E.B.R.S.—400 Bks.

Book 1091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81992

CERTIFICATE OF DEATH.

D 81992

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 16 Rosedale Ave. Ham. St., 27 74-09 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Webster Duvall

(a) Residence No. 16 Rosedale Ave. Hamilton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia J. Duvall

6-DATE OF BIRTH (month, day and year) Aug. 1 1848

7-AGE. 75 yrs. 4 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Track Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Frederick Md.

PARENTS.

10-NAME OF FATHER, John W. Duvall

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Hood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant) Mrs. Duvall (daughter)

(Address) 16 Rosedale Ave.

15- Robert P. Harrison,
Registrar.

DEC 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 21-23

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec. 21 19 23~~ never ~~19~~ ; that I ~~last~~ saw h. ~~alive~~ ~~19~~ ; and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (probable)
Dropped dead in home

Instantaneous

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. M. Bacon M. D

, 19 (Address) Parkville

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Prospect M E Church	12/24, 19 23
20-UNDERTAKER.	**ADDRESS**
J. Fen McCully	130 E. Fort a

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A

D 81993 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 113 D 81993

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 146 Dolphin St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary Dunlap

(Residence in Baltimore: No. 146 Dolphin St. St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: about October 1922
(Month) (Day) (Year)

7-AGE: 1 yrs. 3 mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: William Dunlap

11-BIRTHPLACE OF FATHER, (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Dunlap
(Address) 146 Dolphin St.

15- Robert F. Harrison,
192.
Burial Permit Clerk. Registrar.

DEC 22 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 21, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, an- going (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary): Broncho-Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) J. T. Heuisler M. D.
(Coroner.)

Dec. 22 1923 (Address) 2802 Edmondson Av

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Dec 22 1923

20-UNDERTAKER: Wm Geo Hosier — ADDRESS: 406 W. Pratt St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 81994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 35 Grindon Lane St. Lawnville WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Nitzel

(a) RESIDENCE No. 35 Grindon Lane St. Lawnville WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Frederick Nitzel

6 DATE OF BIRTH (month, day, and year) Sept. 25th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Mies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Doppler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Pilstone

(Address) 35 Grindon Lane

Robert P. Harrison, ...19.... Registrar

Burial Permit Clerk.

DEC 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to December 20, 1923, that I last saw her alive on December 18, 1923 and that death occurred, on the date stated above, at 3:35 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcmoma

(duration) 2 yrs. — mos. —, ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

12/21/1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Dec. 23 1923

20 UNDERTAKER Fred Lassahn & Sons — ADDRESS Fulleston

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—REMOVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81995

CERTIFICATE OF DEATH.

90 D 81995

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 516 Franklin Terrace St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia C. Hessler

(a) Residence No. 516 Franklin Terrace St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas. F. Hessler

6-DATE OF BIRTH (month, day and year) Feb 14th, 1837

7-AGE. 86 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, John P. Knox

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ernestine Demera

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Chas. G. P. Hessler
(Address) 515 Franklin Terrace

15- Dec 24, 1923 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 21st, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 10, 19 23, to Dec 21, 19 23,

that I last saw her alive on Dec 21, 19 23,

and that death occurred, on the date stated above, at 7.55 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. W. Wheaton M. D.

, 19 (Address) 4239 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Dec 24th, 1923

20-UNDERTAKER, Peter Duffy

ADDRESS 1723 W Lafayette Ave

DEC 23 1923

Serial No. [illegible] Clerk.

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81996

CERTIFICATE OF DEATH.

D 81996

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elacha Melamed

(a) Residence No. 115 aisquith stred St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Kaun

6-DATE OF BIRTH (month, day and year)

7-AGE 85 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work nothing

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

11-Informant Jack Louis

(Address) 1439 E Balto St

15-Filed DEC 31 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-22-23

17- I HEREBY CERTIFY, That I attended deceased from Dec 21st, 1923 to Dec 22nd, 1923

that I last saw him alive on, 1923

and that death occurred, on the date stated above, at 10.30 A

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) apoplexy

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Weiman, M. D.

12-22 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Mt Carmel

DATE OF BURIAL, 12-23 1923

20-UNDERTAKER, Jack Louis

ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81997

CERTIFICATE OF DEATH.

74-082

B 81997

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2803 Rockrose ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Esther Flaks.

(a) Residence No. 2803 Rockrose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Kalman Flaks

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE, 56 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER Israel Dorfan

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rosa Sing Todes

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant)..... Jack Lewis

(Address)..... 1439 E Balto St

15- Filed DEC 23 1923, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 22-23

17- I HEREBY CERTIFY, That I attended deceased from June 7, 19 23 to Dec 22nd, 19 23

that I last saw h.er alive on Dec 22nd 19 23

and that death occurred, on the date stated above, at 6 A.M. p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Hepner M. D.

, 19 (Address) 208 N Rose Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 12-23 1923

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 81998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 81998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE, (No. 252 Foster Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John P. Shaner.

(Residence in Baltimore: No. 252 Foster Ave St.; 55 yrs., 5 mos. 21 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 1 (Day), 1868 (Year)

7-AGE, 55 yrs. 5 mos. 21 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John M. Shaner.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Mary Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C. Bursteman

(Address) 410 S. Robinson St.

15-

DEC 23 1923

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1923, to to Dec 22 1923, that I saw h[illegible] alive on Dec 21 1923, and that death occurred, on the date stated above, at [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration)..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) 7 yrs. ..... mos. ..... da.

(Signed) Louis Vogt M. D.

Dec 22, 1923. (Address) 1601 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Pauls Cem. DATE OF BURIAL, Dec. 27, 1923.

20-UNDERTAKER Louis Heman ADDRESS 32 S. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 81999

CERTIFICATE OF DEATH.

90 D 81999

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Vine St ST., 18 WARD)

2-FULL NAME Charles Reed

(a) RESIDENCE NO. 828 Vine St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha P Reed

6 DATE OF BIRTH (month, day, and year) — 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
40		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaning Boats

(c) Name of employer Steam Ship Co

9 BIRTHPLACE (city or town) (State or country) Harbaton Va

PARENTS

10 NAME OF FATHER William Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Frances —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Martha P Reed (Address) 828 Vine St

15 Filed DEC 23 1923, 19 Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 2, 1923, to Dec 21, 1923, that I last saw h.. alive on Dec 19th, 1923, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation & Cardiac Dilatation (duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward Ellacenzie M. D.

Dec 23, 19 (Address) 1339 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Md.	Dec 26 1923
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	1725 Ashland Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001V 82000

D 82000

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Guilford Place ST., 12 WARD)

2-FULL NAME Majorie Jackson

(a) RESIDENCE NO. 1810 Guilford St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27/20

7 AGE ~~Years~~	Months	Days	If LESS than 1 day, ... hrs. or ... min.
9 months			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ... nv
(b) General nature of industry, business, or establishment in which employed (or employer) ... 0
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER alfud mead

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Annie Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Annie Jackson
(Address) 1813 Guilford

15 Filed ....., 192 ..... Robert P. Garrison, Registrar

DEC 23 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchitis
Grandma
(duration) 1 yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Convulsions
Grandma (duration) ... yrs. ... mos. ... ds.

(Signed) Ellis Ridley, M. D.
(Coroner.)
DEC 21 1923 (Address) 1049 Bond

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 22 1923
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 127 Eastland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32001 D 82001

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1412 Rutter (St.) (14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Morris

(a) RESIDENCE. No. 1412 Rutter St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip Morris

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	1881 unknow		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) P. Phillip Morris 1412 Rutter Street.

15 DEC 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19th, 1923, to Dec 20th, 1923, that I last saw h.e alive on Dec 14th, 1923, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Gangrene condition of left foot

(duration) yrs. one mos. one

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) W. Grant Bell, M. D.

, 19 (Address) 3504 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 23 1923
20 UNDERTAKER Wm. R. A. Edwards	ADDRESS 1723 Eastland

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lueticc

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Bks.

D 82002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 82002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Mulliken St., 5 WARD)

2-FULL NAME John Holden

(a) RESIDENCE NO. 1609 Mulliken St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Holden

6 DATE OF BIRTH (month, day, and year) Feb 28 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Dock

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Balto Oakum Factory

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) not known
(State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known
(State or country)

14 Informant .....
(Address) 1609 Mulliken St

DEC 23 1923 Robert P. Harrison, ...19
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 19 23, to Dec 22 19 23,

that I last saw h alive on Dec 21 19 23,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edward Kershner, M. D.

, 19 (Address) 846 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Dec 24 1923

20 UNDERTAKER Mrs. R. C. Elliott

ADDRESS 1725 Eastlandon

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82003

CERTIFICATE OF DEATH.

90

D 82003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1479 W. 36 ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza J. Penn

(a) RESIDENCE NO. 1479 W. 36 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (~~Husband of~~) (or) WIFE of: Enoch E. Penn deceased

6 DATE OF BIRTH (month, day, and year): Jan 1846

7 AGE: Years 77 Months 11 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Caleb Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Wilson Penn

(Address): 3608 Roland Ave

15 Filed DEC 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21st 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1923, to Dec 21st, 1923.

that I last saw h[illegible] alive on Dec 21st, 1923

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Fagrippe Senility

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) B. G. Lilienthal M. D.

Dec 24, 1923 (Address) 1127 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Stamford Dec 24, 23

DATE OF BURIAL

20 UNDERTAKER: W. S. Marshall

ADDRESS 3539 Gay Road

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82004

CERTIFICATE OF DEATH.

90 D 82004

REGISTERED No. C.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 N. Bond ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Mitchell

(Residence in Baltimore: No. 818 N. Bond St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Married

6-DATE OF BIRTH, ... (Month) (Day) 1852 (Year)

7-AGE, 71 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Potter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Matthews Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Richard O Gross (undertaker)

(Address) 1405 McElderry

15- Filed DEC 23 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 21 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1923, to Dec 21 1923, that I saw him alive on Dec 20 1923, and that death occurred, on the date stated above, at 6.55 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

& decompensation

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) R J Young M. D.

12/23, 1923 (Address) 1424 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon

DATE OF BURIAL, Dec 23, 1923

20-UNDERTAKER R B Gross

ADDRESS 1405 McElderry

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82005

CERTIFICATE OF DEATH.

100-901 D 32005

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Tucker

(a) Residence No. 1519 E. North Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1856

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 10

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, James H. Tucker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER, Lottie Carter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto., Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

DEC 23 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 27 1923 to December 20 1923

that I last saw h.er alive on December 19 1923

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Varicose ulcer of leg

(Duration) 3 yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Finding

(Signed) Wm. J. Fulton, M. D

12-20- 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or if deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Lebanon Cem	12/22 1923
20-UNDERTAKER. Edward Reynolds	ADDRESS 2716 Eutaw Pl

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82006 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82006

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 Gengl Sr. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. C. Owens.

(Residence in Baltimore: No. 825 Gengl Sr. St.; 57 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: About (Month) (Day) 1866 (Year)

7-AGE: 57 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General) Odd

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Alex Owens

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Clara Hayden

13-BIRTHPLACE OF MOTHER, (State or Country): Louisiana

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clara Owens

(Address) 547 N. Lafayette Av.

15- Dec 23 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 21 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 22 1923 (Address) 2802 Eutaw Pl.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: St Vincents Cem DATE OF BURIAL: 12/27 1923

20-UNDERTAKER: Samuel Hawley ADDRESS 1727 E Balto

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82007

CERTIFICATE OF DEATH.

90 D 82007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2329 Linden Ave ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Oswald Bryforth

(a) RESIDENCE No. 2329 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma E. Bryforth

6 DATE OF BIRTH (month, day, and year) Aug 6 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale

(c) Name of employer Hooven Owens Rentschler

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Balthasar Bryforth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elz. Stringer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Earl P. Bryforth
(Address) 2329 Linden Ave

Filed ..... 19 .....

Robert F. Harrison,
Registrar
Burial Permit Clerk.

DEC 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21- 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 19 1923 to Dec. 21 1923.

that I last saw him alive on Dec 21 1923,

and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insufficiency

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 3 yrs. mos. da.

18 Where was disease contracted if not at place of death? 2324 Linden Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Charles Luther Wrong M. D.

19 (Address) 3704 Dorchester Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 24 1923

20 UNDERTAKER Henry Tschudi Sons

ADDRESS Northam

Cor.—3-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-9 01 ✓

D 82008

D 82008

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 So. Linwood ave. ST. WARD)

2-FULL NAME John Hartman

(a) RESIDENCE NO. 515 So. Linwood ST., ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Hartman

6 DATE OF BIRTH (month, day, and year) March 6th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U.R.T. Co.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Abrechaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Katie Hartman (Address) 515 So. Linwood Ave

Dec 23 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21st 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to Dec. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Several (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. H. Norton, M. D.
(Coroner)
Dec 21st 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland	12/24 1923
20 UNDERTAKER Fowler & Pickler	ADDRESS 1739 Eager

DEC 23 1923

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION may be of CAUSE OF DEATH in plain terms, so that it may be of great value. See instructions on back of certificate. ATION is very important.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82009

CERTIFICATE OF DEATH.

45 D 82009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2903 Guilford Ave ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Willat

(a) RESIDENCE NO. 2903 Guilford Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth V. Willat

6 DATE OF BIRTH (month, day, and year) Feb 4-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Dyer + Cleaner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Willat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Spichenrider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth V. Willat

(Address) 2903 Guilford Ave

15 Filed DEC 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21-1923

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1923, to Dec 21, 1923, that I last saw him alive on Dec 20, 1923, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma Rectum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) F J Kirby, M. D.

12/21, 1923 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 12/24, 23

20 UNDERTAKER Chas F. Evans & Son — ADDRESS 118 W Mt Royal ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82010

CERTIFICATE OF DEATH.

D 82010

33

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 617 Dumbarton Ave. St. 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles P. Worden

(a) RESIDENCE. No. 617 Dumbarton Ave. St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Francis M. Worden

6 DATE OF BIRTH (month, day, and year) 5. 23. 61.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. P. O.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Worden

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Catherine Eller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. F. M. Worden

Address) 617 Dumbarton ave.

15 Filed DEC 23 1923 , 19 Robert F. Harrison, Registrar

[Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 21. 1923

17 I HEREBY CERTIFY, That I attended deceased from December 23 19 23. to December 21 19 23, that I last saw him alive on December 21 19 23, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) 8 mos. 4 ds.

CONTRIBUTORY (Secondary) Injection of Lace headache

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

19 (Signed) Hallie H. A. Meyer M. D.

(Address) 1011 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	12/24 1923
20 UNDERTAKER	ADDRESS
William Cook	501 E Ltg

E T Y

S • A

Spec.—1-10-21 M&T 1500 Blks.

D. 82011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 82011

CERTIFICATE OF DEATH.

74001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Centre Ave ST., Govans 27 WARD)

2-FULL NAME Eva Schleifer.

(a) RESIDENCE No. 5106 Centre Ave, Govans ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — George Schleifer.

6 DATE OF BIRTH (month, day, and year): Jany 5th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Conrad Bringgold.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Anna Pabst.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Theophila Schleifer. (Address) 5106 Centre Ave. Govans.

15 Filed DEC 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923, to Dec 22nd, 1923, that I last saw her alive on Dec 21st, 1923, and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Paralysis of left side

(duration) ... yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Duncan, M. D.

Dec 22 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery, Govans. DATE OF BURIAL: Dec 24 " 1923

20 UNDERTAKER: Wm J. Hartnett. ADDRESS 2256 W. Baltimore St.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

Spec.—1-10-21—M&T—1500 Blks.

Lonie A. Schools

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82012

CERTIFICATE OF DEATH.

129 D 82012

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 148 W. Cross ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lonie A. Schools

(a) RESIDENCE No. 148 W. Cross ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Schools

6 DATE OF BIRTH (month, day, and year): Aug. 27, 1883

7 AGE: Years 40 Months 4 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Frank Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Adaline Cannuke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Information: Edw Schools

(Address) 148 W. Cross St.

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

DEC 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Dec. 21, 1923.

that I last saw her alive on Dec 21, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) C. A. Eichenbrater M. D.

Dec 22-23, 19 (Address) 1712 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL 12/27/1923

20 UNDERTAKER: Margaret O. Flynn — ADDRESS 1412 Eutaw St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82013

CERTIFICATE OF DEATH.

12 9 D 82013

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave St.: 70 Ward)

2-FULL NAME Mrs. Sophronia B. McDonnal

(a) RESIDENCE. No. Home for the aged of the M.E. Church St.: Ward:
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16. 1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	—	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jno. Haynie.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Ann Cohee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Ettie Cuddy
(Address) 406 N. Fulton Ave

15 Filed DEC 23 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to Dec. 22, 1923, that I last saw h[illegible] alive on Dec 19, 1923, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

1 Nephritis Chronic (duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Coma — (duration) — yrs. — mos. 2d ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual.

(Signed) George C. Shannon, M. D.

12/23 1923 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec 24 1923
20 UNDERTAKER	ADDRESS
George J Smith	1532 Hollins st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82014

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D 82014

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 200 N. High 5 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Moses Robinson

(Residence in Baltimore: No. 200 N. High St.; 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Married

6 DATE OF BIRTH: Unknown (Month) (Day), 1871 (Year)

7 AGE: 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Robert Robinson

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Levine

(Address) 1497 E. Baltimore St.,

15 DEC 23 1923

Robert P. Harrison, 191
REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 23rd, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22nd, 1923, to Dec 23 1923 that I saw him alive on Dec 23rd, 1923 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Morris Friedman M. D.

Dec 23, 1923 (Address) 2328 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cemetery Run

DATE OF BURIAL: 12-24- 1923

20 UNDERTAKER: Jack Levine, 1497 E. Balto

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82015

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1127 Harlem Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisabeth McGinnis

(a) Residence No. 1127 Harlem Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): June 1849

7-AGE: 74 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: George E Cook

11-BIRTHPLACE OF FATHER (City or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country): Ireland

14-Informant: Mrs George Haas

(Address) 1127 Harlem Ave

15-Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 21-1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 19, 1923 to Dec 21 1923

that I last saw h alive on Dec 21 1923,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH was as follows:

Acute Cardiac Dilatation 2 day

Chr Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chr Ost Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Chandler M. D

Dec 22 1923 (Address) 1504 McCulloh

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec 24 1923

20-UNDERTAKER: Martin Luckey Sons — ADDRESS: 827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

82016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82016

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W Schroder ST., 18 WARD)

2-FULL NAME May Emily Shipley

(a) RESIDENCE NO. 17 W Schroder ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	col	mar

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Geneva Johnson
(Address) 17 W Schroder St

Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gorsuch, M. D.
(Coroner.)

12-22 1923 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 24 1923
20 UNDERTAKER	ADDRESS
A Jones	111 S Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Cystitis Sputum Pulmonary Tuberculosis

.....

.....

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82017

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-91 82017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Royal Apts ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie George Cromwell

(a) RESIDENCE NO. Mt Royal Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Cromwell

6 DATE OF BIRTH (month, day, and year) May 29th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md

PARENTS

10 NAME OF FATHER P. T. George

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Philip D. Cromwell (Address) 1224 E. Biddle

15 Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/21 1923

17 I HEREBY CERTIFY, That I attended deceased from — 1919, to 12/21, 1923, that I last saw her alive on 12/21, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

6 hours

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

aged 70 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edward Lehart, M. D.

12/22 1923 (Address) 1402 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Dec 24 1923

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Pulaski

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82018

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 E Federal ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leah D. Hunkle

(a) RESIDENCE NO. 2303 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER John Dice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Susie E. Hunkle 2303 E Federal St.
(Address)

DEC 24 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22. 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 3 1923. to Dec 22 1923.
that I last saw h[illegible] alive on Dec 22 1923.
and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) D. O. Herzog M.D. M. D.

12/24, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Md. DATE OF BURIAL Dec 24 1923

20 UNDERTAKER Clark Johnson ADDRESS 1 W Fayette

Spec. 1-1021 MAT 1500

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 82066

CERTIFICATE OF DEATH.

100-001 D 82019

1 PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 5 WARD)

2-FULL NAME Willie Robinson

(a) RESIDENCE NO. 101 East St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Aug 26 1922

7 AGE: Years 1 Months 4 Days 1

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Willie Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D. C.

12 MAIDEN NAME OF MOTHER: Ethel Robenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Registrar: ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to Dec 21, 1923, that I last saw him alive on Dec 21, 1923, and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Primary bronchopneumonia

(duration) ..... yrs. ..... mos 18 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ..... yrs. ..... mos. 14 ds. ?

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) A. A. Reed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Astery Cemetery — DATE OF BURIAL: Dec 24 1923

20 UNDERTAKER: Mrs Robert R. Elliott — ADDRESS: 1725 — Ashland

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82020

CERTIFICATE OF DEATH.

160 D 82020

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Brice ST.: 70 WARD)

2-FULL NAME Joseph Francis Raney

(a) RESIDENCE. No. 411 Brice ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	boy

5a If married, widowed, or divorced HUSBAND of (or) WIFE of boy

6 DATE OF BIRTH (month, day, and year) Oct 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John P. Raney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Laura V. Pickering

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mother 411 Brice St.

15 Filed DEC 24 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1923, to Dec 22, 1923, that I last saw h in alive on Dec 22, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows: Rachitis; Malnutrition; Respiratory Collapse

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Gastritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Walter Richard, M. D.

, 19 (Address) 411 Brice St. Locality Old.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Dec 24 1923
20 UNDERTAKER	ADDRESS
Harry H Witzke	153 N Fremont Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 32021 — 179 — D 32021

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. S.W. Cor. Edmondson Ave & Woodside Rd St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME BERTHA MAY ABHAU

(a) Residence No. S.W. Cor. Edmondson Ave. & Woodside Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles H Abhau

6-DATE OF BIRTH (month, day and year) Sept 7 1869

7-AGE, 54 yrs. 2 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, F. Ph. Henninghausen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eva S. Lepley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Frostburg Md

14-

(Informant) Charles H. Abhau

(Address) S.W. Cor. Edmondson Ave & Woodside Rd

15-

Dec 23 1923

ROBERT R. KRAUTER Registrar.

DEC 24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 22. 23.

17- I HEREBY CERTIFY, That I attended deceased from January 1923 to December 22 1923

that I last saw her alive on 17 December 1923

and that death occurred, on the date stated above, at 12 12 P m.

The CAUSE OF DEATH* was as follows:

Nephritis interstitial Chronic

Uraemia

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. H. Abhau M. D.

Dec 23 1923 (Address) 2438 Auburn Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Jerusalem (Lutheran) Cem.	Dec. 24. 1923
20-UNDERTAKER, John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82022

90 D 82022

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. 3 Somerset Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rachael Sadtler

(a) RESIDENCE NO. Church Home & Infirmary ST. WARD Newport
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Sadtler

6 DATE OF BIRTH (month, day, and year) May 18 1839

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Noah Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Chas H Sadtler
(Address) 411 W. Franklin St.

15 Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17

I HEREBY CERTIFY, That I attended deceased from 10-21, 1923, to Dec 22, 1923, that I last saw h[illegible] alive on Dec 22, 1923, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH was as follows:

Myocardial Insufficiency
Chronic Valvular disease of Long Standing

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Dr. Mary Sanctuary, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Dec 24 1923.
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82023

CERTIFICATE OF DEATH.

74-D 82023

1-PLACE OF DEATH

City of BALTIMORE: (No. 2817 Norfolk Av St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Benj. Goldberg

(Residence in Baltimore: No. 2817 Norfolk Av St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. about (Month) 1.86 (Day) (Year)

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Shipwreckers

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Harry Goldberg

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rosie ?

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Goldberg

(Address) 2817 Norfolk Av.

15 Filed. 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

DEC 24 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 23 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. E. Hemmeter, M. D. (Coroner)

Dec. 23 1923 (Address) 258 E. Lanvale St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale DATE OF BURIAL. 12/24 1923

20-UNDERTAKER. Sol Levinson & Bro ADDRESS 1127 Baltimore St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82024

CERTIFICATE OF DEATH.

167-001

167 D 82024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N. Belair Rd. ST., 26 WARD)

2-FULL NAME Richard D. Plowman

(a) RESIDENCE No. 610 N. Belair Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V. Plowman

6 DATE OF BIRTH (month, day, and year) Dec 10/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Store-keeper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James R. Plowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Haceamy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella V. Plowman
(Address) 610 N. Belair Rd.

15 Filed DEC 24 1923, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Probably Suicide

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Watson, M. D.
(Coroner.)

Dec 23/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	12/24 1923
20 UNDERTAKER Geo. Weber & Son	ADDRESS 2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82025

100-001

D 82025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mallonee

(a) RESIDENCE NO. 2005 Gerard Avest., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Record (Address)

15 Filed DEC 24 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-21-1923

17 I HEREBY CERTIFY, That I attended deceased from 12-21-23, 19 to 12-21, 19 23, that I last saw him alive on 12-21, 19 23, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Senile Heterination

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Drane, M. D.

12-22 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Dec 24, 23

20 UNDERTAKER Chenoweth Son ADDRESS Cheatnute

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchopneumonia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82026

CERTIFICATE OF DEATH.

B 82026

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Furman Vaughn Gaines (Lelian)
560 W. 165th St

(a) RESIDENCE NO. ST., WARD New York City, N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —— yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Furman Vaughn Gaines

6 DATE OF BIRTH (month, day, and year) Mar. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housf. 027

(c) Name of employer

9 BIRTHPLACE (city or town) New York City, N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Mr. F. Konrad Keller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) germany.

12 MAIDEN NAME OF MOTHER Sophia.

13 BIRTHPLACE OF MOTHER (city or town) New York City N.Y.
(State or country)

14 Informant Mrs. Furman Vaughn Gaines
(Address) 560 W. 165th St. New York.

15 Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to Dec. 24, 1923,
that I last saw h.. alive on Dec. 24, 1923,
and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

60 W

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? N. Y. City

Did an operation precede death? Yes Date of August 21, 23

Was there an autopsy? No.

What test confirmed diagnosis? Medical examination.

(Signed) Robert E. Fricke, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York city	Dec 24. 1923

20 UNDERTAKER ADDRESS
Chas. G. Blacket 742 Lexington Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exophthalmic Goitre

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82027

CERTIFICATE OF DEATH.

D 82027

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 19th St. (ST.) Brooklyn (WARD) 25

2-FULL NAME Florence Kosack.

(a) RESIDENCE. NO. 10th St (ST.) Brooklyn WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lawrence Kosack

6 DATE OF BIRTH (month, day, and year): Jun 26 1879

7 AGE: Years 44 · Months 10 · Days 26 · If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John L. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Mary E. Fillinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant (Address): Lawrence Kosack 10th Brooklyn Balto Md

15 Filed DEC 24 1923 19.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1920, to Dec 22, 1923, that I last saw her alive on Dec 21, 1923, and that death occurred, on the date stated above, at 7:32 p. m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) R. O. Gleeson M. D.

Dec 23, 1923 (Address) 50 Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Dec 25 1923
20 UNDERTAKER	ADDRESS
E. Schloman & Son	Hanover St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

82028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82028

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 W. Saratoga ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Robinson

(a) RESIDENCE No. 501 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, / hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Maryland

12 MAIDEN NAME OF MOTHER Alice Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Towson Md

14 Informant Wm Robinson (Address) 501 W. Saratoga

15 DEC 24 1923 ROBERT R. KRAUTER, Burial Permit Registrar Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1923, to Dec 22, 1923, that I last saw him alive on Dec 22, 1923, and that death occurred, on the date stated above, at 7:22 m.

The CAUSE OF DEATH* was as follows:

Prematurity 36 Weeks Gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis, Maternal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. F. F. Hundley, M. D.

, 19 (Address) Universal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Dec 24 1923

20 UNDERTAKER: Elmer Alexander — ADDRESS: 520

Drug poisoning

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82029

CERTIFICATE OF DEATH.

188 2003 D 82029

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Franke

(a) RESIDENCE No. 122 N luzerne Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Franke

6 DATE OF BIRTH (month, day, and year): Dec 12/1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Franke
(Address): 1735 Montpelier St

15 Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
Automobile accident

(Inquest Dec 26/23) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Dorsey, M. D. (Coroner.)

Dec 25 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H Mathias	De 26 192
20 UNDERTAKER	ADDRESS
Louis Heemans	325 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ruth Gross

D 82030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82030

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 14 Ward) 188-003

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ruth Gross

(Residence in Baltimore: No. 2110 O'Neill ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: (Month) Dec (Day) 22 (Year) 1918

7-AGE: 5 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto city

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Gross

(Address) 2110 O'Neill ave

15-

Filed DEC 24 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Dec (Day) 22 (Year) 1923

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(Duration) yrs. mos. 2 ds.

(Signed) H K Gruwell M. D. (Coroner.)

12-24 1923 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Dec 24 1923
20-UNDERTAKER, John H. Jordan	ADDRESS 142 W Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82031

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 82031

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2427 Linden Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Mason.

(a) Residence No. 2427 Linden Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alicia T. Mason

6-DATE OF BIRTH (month, day and year) July 4/1870

7-AGE. 53 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.°

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Assistant Supt

(b) General nature of industry, business, or establishment in which employed (or employer) Bur. of W. Work

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Portland Ind

PARENTS.

10-NAME OF FATHER, John M. Mason

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Barnsville Ohio

12-MAIDEN NAME OF MOTHER, Morning Jane Thomas

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Pennville Ind

14-

(Informant) S. L. Mason

(Address) Kansas City Kas.

15-

Filed..... 192.....

ROBERT R. KRAUTE
Registrar.

Burial Permit Issued

DEC 24 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 23. 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1923, to Dec. 23 1923,

that I last saw h.. alive on Dec. 23 1923,

and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Varicocele

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was There an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Whitehouse M. D

, 19 (Address) 1510 Eutaw Place.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Nickerson Kansas	Dec 25 1923
20-UNDERTAKER.	ADDRESS
David Sondheim	18 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82032

CERTIFICATE OF DEATH.

100-001 D 82032

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Women's Hospital, John + Eolaw sts ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emily Winifred Waterhouse.

(a) RESIDENCE NO. 1694 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	2	23	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Dr. William E. Waterhouse

11 BIRTHPLACE OF FATHER (city or town) Ridgefield, (State or country) Connecticut.

12 MAIDEN NAME OF MOTHER Margaret A. Gusey

13 BIRTHPLACE OF MOTHER (city or town) Shrewsbury, (State or country) Pa.

14 Informant Mrs. Julia A. Dorsey (Sister)

(Address) 2811 Kiggs Ave. City

15 DEC 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1923, to Dec. 23, 1923, that I last saw her alive on Dec. 23, 1923, and that death occurred, on the date stated above, at 6 25 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Decompensation.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician + X-ray.

(Signed) J. Ogle Warfield, Jr., M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 25 1923
20 UNDERTAKER	ADDRESS
H M Routson	2258 N Smith

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82033 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 8 Ward) 196

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Kleinsicker

(Residence in Baltimore: No. 3011 Erdman Ave St.; yrs., mos. ds.)

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Dec (Month) 23 (Day) 1901 (Year)

7-AGE: 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician 12
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Chas B. Kleinsicker

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Regina Boyle

13-BIRTHPLACE OF MOTHER, (State or Country): B. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Chas B. Kleinsicker

(Address) 3011 Erdman Ave

15-

Filed ..... 192.....

Robert P. Harrison,
Registrar.

DEC 24 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock from Comy in contact with Fix. Electric Conductor a few hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Bonnell M. D.
(Coroner.)

12-24 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL: Dec. 26 1923

20-UNDERTAKER: Henry Hirsch Son ADDRESS 130 E Eager St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82034

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 D 32034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 W. Lexington ST., 20th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave Homrighausen,

(a) RESIDENCE NO. 1804 W. Lexington ST., 20th WARD 12

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Augusta Homrighausen,

6 DATE OF BIRTH (month, day, and year) Feb. 12. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Philip Homrighausen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Augusta Homrighausen
(Address) 1804 W. Lexington St.

DEC 24 1923

15 Filed ..... Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23. 1923

17

I HEREBY CERTIFY, That I attended deceased from December 16, 1923, to December 23, 1923, that I last saw h[illegible] alive on December 23d, 1923, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (bronchial)

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Vassallo, M. D.

Dec 3 1923 (Address) 525 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park Cem.

DATE OF BURIAL Dec. 26. 1923

20 UNDERTAKER Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82035

CERTIFICATE OF DEATH.

28 129

D 82035

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Forest Park Ave. nr. Windsor Mill Road)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Thomas Lowe

(a) Residence No... Forest Park Ave. nr. Windsor Mill Road St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Lowe

6-DATE OF BIRTH (month, day and year) Apr. 6, 1839

7-AGE.	If LESS than 1 day,
84 yrs. 8 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer on farm

(b) General nature of industry, business, or establishment in which employed (or employer)..... 40 0

(c) Name of employer.....

9-BIRTHPLACE (City or County), (State or Country). Prince William County Virginia

PARENTS.

10-NAME OF FATHER, Harry Lowe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Matilda Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Mrs. Maurice Smith
(Address) Hillsdale, Md.

15- Filed ..., 192 ..... Registrar.

DEC 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 22, 1923, that I last saw him alive on Dec 21, 1923, and that death occurred, on the date stated above, at 3.10 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis —
Chronic parenchymatous Nephritis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter Tibbett, M. D.

12-22, 1923 (Address) 2220 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cem. DATE OF BURIAL. Dec 24, 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82036

D 82036

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 916 Madison Ave. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lawrence Le Gourd

(a) Residence No. 916 Madison Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. LeGourd

6-DATE OF BIRTH (month, day and year) Oct. 17, 1862

7-AGE.	If LESS than 1 day.
61 yrs. 2 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Electrician

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore County Maryland

PARENTS.

10-NAME OF FATHER, Lawrence Louis LeGourd

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Sallie Small

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14. (Informant) Helen M. Brannan

(Address) 916 Madison Ave.

15. Filed DEC 24 1923, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 21, 1923

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1923, to Dec 21, 1923, that I last saw h.. alive on Dec 20, 1923, and that death occurred, on the date stated above, at 1.15 A.

The CAUSE OF DEATH* was as follows:

Aneurism Aorta

about (Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

Few hours (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Edward P. Smith, M. D.

12-21 19 23 (Address) 16 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Dec 24 19 23
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably Lueti

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82037

CERTIFICATE OF DEATH.

83 D 82037

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 Oakmont ave ST., 27 WARD)

2-FULL NAME John Obrien

(a) RESIDENCE NO. 228 Oakmont av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Obrien

6 DATE OF BIRTH (month, day, and year) July 4 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	79	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Detrick & Harvey

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Obrien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Barbara Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Longmead

(Address) 229 Oakmont ave

DEC 24 1923 Filed ..... 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Dec 23, 1923, that I last saw him alive on Dec 21, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J. Wells, M. D.

, 19 (Address) 7 W Belvedere ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Dec 26 1923

20 UNDERTAKER John T. Hartley — ADDRESS 845 N. Warwick

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82038

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82038

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belair Road & Kenwood ave. Overlea ST., 26 WARD)

2-FULL NAME William G. Segrist

(a) RESIDENCE NO. Belair Road & Kenwood ave. Overlea ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Segrist

6 DATE OF BIRTH (month, day, and year) Oct 15 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Segrist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Barbara Segrist (Address) Ruxberg Md.

15 Filed DEC 24 1923 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Dec 22 1923 that I last saw h[illegible]live on Dec 22 1923 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

(duration) 5 yrs. + mos ds.

CONTRIBUTORY (Secondary) myocardial failure

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

. 19 (Address) 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 26 1923
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

Spec.—1-10-21—M&T—1500 Blks.

D 82039

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 82039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Ulchinsky

(a) RESIDENCE NO. 116 S. Greene St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Tony C. Ulchinskey

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(h) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Joe Kostak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Helen Meketas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: Records. (Address) 116 Green Street

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

DEC 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/23/1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1923, to Dec. [illegible], 1923; that I last saw her alive on Dec. 22 [illegible], 1923 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage Rt. side

Chronic hypertension

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At residence of patient

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John M. Edmonds, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leuden park Cemetery	Dec 26, 1923

20 UNDERTAKER: [illegible] ADDRESS 637 S. [illegible] St. Chas. Kirchenberg

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82040

CERTIFICATE OF DEATH.

154-001

D 82040

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 - 4th St Fairfield ST.; 25 WARD)

2-FULL NAME Child of Floyd Brad Long

(Residence in Baltimore: No. 29 4th St Fairfield St.; ....yrs....mos....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Dec 22, 1923 (Month) (Day) (Year)

7-AGE, ...yrs....mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Floyd Long

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Pearl Vanlandingham

13-BIRTHPLACE OF MOTHER (State or Country), N. C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Long

(Address) 29 4th St

15-

Filed....., 191.....

DEC 24 1923

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12/22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/22/23 191..., to 12/22/23 191..., that I saw h[illegible] alive on 12/22/23 191..., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.

12/23, 191... (Address) 134 Aisquith

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Furnace Branch

DATE OF BURIAL, Dec 24, 1923

20-UNDERTAKER John H. Toadvine

ADDRESS 143 Aisquith St

MARGIN RESERVED FOR BINDING

12.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82041

CERTIFICATE OF DEATH.

91-002 ✓ D 82041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 E. Biddle ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Murphy

(a) RESIDENCE NO. 603 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Murphy

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Bondell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Murphy

(Address) 603 E. Biddle St

15 DEC 24 1923 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. , 1923 , to Dec 22. , 1923 ,

that I last saw her alive on Dec 21 , 1923 ,

and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs + symptoms

(Signed) Mary F. Douglass, M. D.

19 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Dec 26 1923
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Ave

S·A·F·E

DARK

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82042

CERTIFICATE OF DEATH.

188-003 ✓ D 82042

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ebben Gamse (Gammie)

(a) RESIDENCE NO. 1024 E. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 31-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas J Gamse

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Ward

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant C E Fennell
(Address) 1526 E Northern

15 Filed DEC 24 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cut Flaps & Internal injuries
Death resulted from Burns
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Accident
(duration) ....yrs. ....mos. ....ds.

(Signed) W. R. Donaldson, M. D.
(Coroner.)
12-22, 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Dec 26	1923

20 UNDERTAKER H. C. Wiesenfeld ADDRESS 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-16-21—M&T—1500 Blks.

D 82043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D 82043

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Gorsuch ave ST., 9 WARD)

2-FULL NAME Fennie Diver

(a) RESIDENCE No. 611 Gorsuch ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John W. Diver

6 DATE OF BIRTH (month, day, and year) Sept. 11. 1843

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	80.	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Colborn. Canada.

PARENTS

10 NAME OF FATHER John Ray.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada.

12 MAIDEN NAME OF MOTHER Fennie Ray.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada.

14 Informant Frank G. Diver

(Address) 611 Gorsuch ave

15 Filed ..... 19 .....

Registrar

DEC 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1923, to Dec. 23 1923, that I last saw her alive on Dec 23 1923, and that death occurred, on the date stated above, at 5 - P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, "Cardiac dilatation

(duration) Years yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis "Asthma

(duration) yrs. Years mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. G. Prentiss, M. D.

, 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Royal Laundry

DATE OF BURIAL Dec 27 1923

20 UNDERTAKER George F. Ruth, 1735 Harford ave

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82044

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH 1520 North Broadway

CITY OF BALTIMORE: (No. 1520 N. Broadway ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis P. Kornmann

(a) RESIDENCE NO. 1520 N. Broadway ST., 8 WARD.....
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widower

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Louisa Kornmann

6 DATE OF BIRTH (month, day, and year) July 5 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.... min.
	73	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retail Cigar Store

(b) General nature of industry, business, or establishment in which employed (or employer): and Office

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Rudolph Kornmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Louis P. Kornmann Son

(Address) 1520 N Broadway

15 DEC 25 1923 ROBERT R. REMSEN Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1923, to Dec 23, 1923.

that I last saw him alive on Dec. 22, 1923,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Adolf Moadsand, M. D.

Dec 23, 1923 (Address) 154 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Dec 27th 1923

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82045

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓

D 82045

REGISTERED No. C 9

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 823 E 33rd ST.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H Dreyer

(Residence in Baltimore: No. 823 E 33rd St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: April 16, 1896 (Month) (Day) (Year)

7-AGE: 27 yrs. 8 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Vice President
(b) General nature of industry, business, or establishment in which employed (or employer): H. D. Dreyer & Bro

9-BIRTHPLACE (State or country): Balto Md

PARENTS

10-NAME OF FATHER: Henry D Dreyer

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Anna M Runte

13-BIRTHPLACE OF MOTHER (State or country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry D Dreyer

(Address) 823 E 33rd St

15-Filed DEC 25 1923 ROBERT R. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 23, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923 to Dec 23 1923.

that I saw h[illegible] alive on Dec 23, 1923

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Bilo nephritis — Uremia

(Duration) yrs. mos. ds

Contributory (SECONDARY): Lobar pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) Harry S Bell M. D.

Dec 24, 1923 (Address) 208 Cristian St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: 12-26, 1923

20-UNDERTAKER: Wm Chas A & J Roberts

ADDRESS: 600 Arlington

Spec.—1-10-21—M&T. 1500 Blks.

D 82046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 Belt Ave St., 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa P. Schmuck.

(a) RESIDENCE No. 1644 Belt Ave St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Female~~	White	Widow

5a ~~If married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of George J. Schmuck

6 DATE OF BIRTH (month, day, and year) Sept. 17-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Laurence Bopp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Gertrude Schmuck

(Address) 1644 Belt Ave

15 Filed DEC 25 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 1923, to Dec 24 1923,

that I last saw her alive on Dec 24 1923,

and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Wiselate M. D.

1923 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A&S	12-27 1923
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E West St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82047

D 82047

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13 WARD)

2-FULL NAME George Zangenberg

(a) RESIDENCE No. 14 Prospect Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 009

(b) General nature of industry, business, or establishment in which employed (or employer) Stock Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Zangenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ruffert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hospital Record (Address)

15 Filed DEC 25 1923 ROBERT R. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25/23 19

17 I HEREBY CERTIFY, That I attended deceased from 12/23/23, 19.... to 12/25/23 19....

that I last saw h alive on 12/25/23 19....

and that death occurred, on the date stated above, at 7.00 9 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelly M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel C	Dec 27 1923
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatism —
Bad teeth + diseased
Tonsils

Spec–12-23-21–E.B.R.S.–400 Bks.

D 82048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1711 Dr. Clinton St., 26 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Scott

(a) Residence No. 1711 Dr. Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House 070

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, Forbes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Watson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Geo Scott

(Address) 1711 Dr Clinton St

15- Filed DEC 25 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 23, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 8, 1923, to Dec 23, 1923, that I last saw h[illegible] alive on Dec 21, 1923, and that death occurred, on the date stated above, at 12 05 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficency

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Forbes, M. D.

12-24, 1923 (Address) 1612 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pet B'[illegible] | DATE OF BURIAL, Dec 25, 1923

20-UNDERTAKER, Theodore Hirth | ADDRESS 119 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec,—1-10-21—M&T—1500 Bks.

D 82049

HEALTH DEPARTMENT—CITY OF BALTIMORE

132 D 82049

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 N Bond. ST., 8 WARD)

2-FULL NAME Blanche M. McCormick

(a) RESIDENCE NO. 1822 N Bond St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E McCormick

6 DATE OF BIRTH (month, day, and year) Sept 2 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Terrence Lannon

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Harding

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mary Lannon (Address) 1822 N Bond

15 Filed DEC 25 1923, 19 ROBERT R. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1920, to Dec 22, 1923, that I last saw her alive on Dec 22, 1923, and that death occurred, on the date stated above, at 4 10 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

Multiple Kidney stones

(duration) 3 yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray (Urin)

(Signed) Thos F Sellers, M. D.

12/27/23 1923 (Address) 2876 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 26 1923

20 UNDERTAKER E A Wiedefeld Jr — ADDRESS 501 E 22

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 82050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82050

160

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Hallem

(a) RESIDENCE No. 2317 Callow Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10th-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	✓	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Hallem

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Cohen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14
Informant Joseph Hallem
(Address) 2317 Callow Ave.

15
Filed DEC 25 1923 ROBERT R. KRAUTER Registrar
Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 -24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined (bottle fed)

(duration) yrs. mos. ds.

(Signed) Jos. S. B. Fallen, M. D.
(Coroner.)

Dec 25/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	12-25-1923
20 UNDERTAKER	ADDRESS
Jack Lewis 1439	E. Balto.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Bks.

D 82051 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82051

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Monument st St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Rosenberg

(a) RESIDENCE No. 17 W. Hill st St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
(or) WIFE of Becky Rosenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Circus Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto. St.

15 Filed DEC 25 1923 ROBERT R. KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1923, to Dec. 24, 1923, that I last saw him alive on Dec. 24, 1923, and that death occurred, on the date stated above, at 11:55 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute bacterial endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/22/23

Was there an autopsy? Yes

What test confirmed diagnosis? clinical + autopsy

(Signed) A Bruder Sondheimer, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom DATE OF BURIAL 12-25 1923

20 UNDERTAKER Jacob Lewis, 1439 ADDRESS E. Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Thrombosis & Gangrene
Left Leg.
No History

Spec.—1-10-21—M&T—500blks.

16934 82052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 82052

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Ellwood Schumacher

(a) RESIDENCE NO. 1944 W. Herbert St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 4, 1923

7 AGE — Years | 3 Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Nail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Schupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 DEC 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1923, to Dec 23, 1923, that I last saw him alive on Dec 23, 1923, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Anaemia (unknown etiology)

(duration) Life yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) H.H. Wood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 26, 1923

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

Waldo

D 82053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82053

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 137 N. Highland Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Gertrude Walden

(a) Residence No. 137 N. Highland Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George E.

6-DATE OF BIRTH (month, day and year) March 7, 1888

7-AGE, 35 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Grimm

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Margaret Hoffman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Wilhelmina E Walden

(Address) 137 N. Highland Ave

15- Filed DEC 26 1923 ANGELO R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 24 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 22, 1923, to Dec 24, 1923, that I last saw h[er] alive on Dec 24, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

1. Carcinoma Left Breast

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Liver

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? yes Date of about Nov 1/23

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) Jos Schreiber, M. D.

Dec 25, 1923 (Address) Jos Schreiber

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Dec DATE OF BURIAL. 27, 1923

20-UNDERTAKER Wm Cook ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82054

CERTIFICATE OF DEATH.

D 82054

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Milton ST., W WARD)

2-FULL NAME Frank Wagner

(a) RESIDENCE NO. Ann St (Clarkmount) ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (Write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) ? ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	60.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Southern

(c) Name of employer Can Company

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant John W. Frederich
(Address) 1940 N. Bloomfield Ave.

15 DEC 26 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/22, 1923 to 12/25 1923.

that I last saw him alive on 12/25/23, 1923

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cystitis

?

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Hydronephrosis - Uremia

(duration) yrs. 4 days mos. ds.

18 Where was disease contracted, if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? yes autopsy

What test confirmed diagnosis? .....

(Signed) A. G. Turnbull, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Dec 27 1923
20 UNDERTAKER Wm. Cook	ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

001

18 D 82055

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 N. Grove St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mrs. Wm. Makus

(Residence in Baltimore: No. 115 N. Grove St., 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Unknown ....., 1.....
(Month) (Day) (Year)

7-AGE. About 53 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), N. York.

PARENTS.

10-NAME OF FATHER, John Henry

11-BIRTHPLACE OF FATHER, (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Makus

(Address) 1661 W. Fayette St

15.

Filed. DEC 26 1923 19.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 21 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry.) find that said deceased came to. Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) ..... yrs. a few hrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Gorsuch M. D.
(Coroner.)

12-24, 1923 (Address) 117 W. Saratoga St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. 115 N. Grove

19-PLACE OF BURIAL OR REMOVAL, Oakland — DATE OF BURIAL, Dec 26, 1923

20-UNDERTAKER. Wm. Good — ADDRESS 502 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82056

CERTIFICATE OF DEATH

D 82056

1-PLACE OF DEATH City of BALTIMORE (No. 885 W Fayette St., ... Ward) Registered No. .....

2-FULL NAME John Otto Schaffer

(a) Residence No. 885 W. Fayette St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline

6-DATE OF BIRTH (month, day and year) Oct 4 1838

7-AGE. 85 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Husker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.
10-NAME OF FATHER, Schaffer
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12-MAIDEN NAME OF MOTHER Caroline Warnick
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14-Informant Annie Kane
(Address) 855 W. Fayette

15-DEC 26 1923 ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 23 1923.

17- I HEREBY CERTIFY, That I attended deceased from December 17, 19 23, to December 23 19 23
that I last saw him alive on ..... " ", 19 .....
and that death occurred, on the date stated above, at 10:05 P. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Myocarditis
.....
.....(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia
.....(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Edw. W. Cookson, M. D.
12/24, 19 23 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery | DATE OF BURIAL, 12/26, 19 23

20-UNDERTAKER Lon Cook | ADDRESS 532 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82057

CERTIFICATE OF DEATH.

74-001 D 82057

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Martha A Smoot (60)

(a) RESIDENCE NO. Baltimore Md ST. Harlem WARD 1714

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William Barton

6 DATE OF BIRTH (month, day, and year) Feb 3-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm S. Forrest.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Constable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Eugenia L. Smoot (Address) 1714 Harlem ave

15 Filed DEC 26 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Register.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-21- , 1923, to 12-26 , 1923, that I last saw her alive on Dec 25 , 1923, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis chr. nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Keith C. Rice, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 27 1923
20 UNDERTAKER Jas Cook	ADDRESS 502 E Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

) 82058

HEALTH DEPARTMENT—CITY OF BALTIMORE

82058

CERTIFICATE OF DEATH.

N-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Dolphin ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward D. Harding

(a) RESIDENCE NO. 331 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed or divorced HUSBAND of (or) ~~WIFE~~ of Mary E. Harding

6 DATE OF BIRTH (month, day, and year) March 31, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) Self 086

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md

(State or country)

PARENTS

10 NAME OF FATHER James Harding

11 BIRTHPLACE OF FATHER (city or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Marshall

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Joseph Deibert

(Address) 301 Dolphin St

15 Filed DEC 26 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25th 1923

I HEREBY CERTIFY, That I attended deceased from Dec 24th, 1923, to Dec 25th, 1923, that I last saw him alive on Dec 24th, 1923, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. Abt 11 Hours mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. 11 Hours mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) H. Mech, M. D.

, 19 (Address) 607 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Dec 27th 1923

20 UNDERTAKER William Cook — ADDRESS 512 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82059

CERTIFICATE OF DEATH.

90 D 82059

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 N. Fulton ave ST.: 16 WARD)

2-FULL NAME Robert R. Moling

(a) RESIDENCE. No. 703 N. Fulton ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Allie B. Moling

6 DATE OF BIRTH (month, day, and year) June 3 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Structural Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm Moling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant H. J. Chadwell

Address) 703 N Fulton Ave

Filed DEC 26 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 9 1923, to Dec. 25 1923, that I last saw h[illegible] alive on Dec. 25 1923, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pyelo-Nephritis, Edema of Lungs & inanition

Two weeks & two days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Degeneration, about

(duration) 74 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? The usual

(Signed) Carlton M Cook, M. D.

Dec 25 1923 (Address) 2219 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	Dec 26 1923
20 UNDERTAKER Geo W Little	ADDRESS 2700 EDMONDSON AVE.

Spec.—6-9-19—H. P. Co.—1000 Bkz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32060

CERTIFICATE OF DEATH.

129 ✓ D 82060

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McNeal

(a) RESIDENCE. NO. Mt Hope Retreat ST., 25 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 67 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
Abt	67	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick. Md
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country)

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14 1923, to Dec 23, 1923, that I last saw h...live on Dec 23, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

Abt (duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Man. Psychosis - (duration) 30 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Frederick Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank H Flannery, M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 26 19 23
20 UNDERTAKER STEWART & MOWEN COMPANY (Successor to WILLIAM F. WOODEN)	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82061

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Elmora

CITY OF BALTIMORE: (No. 3135 Elmora Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Lyons

(a) RESIDENCE NO. 3135 Elmora Ave ST., Elmora ave WARD near Belair Rd

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~(wife) (husband)~~ of ~~(last) Wife~~ of Husband Alice E Lyons

6 DATE OF BIRTH (month, day, and year) Sept 18-1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager Furniture

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John H Lyons

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Margt. Heldebaugh

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Alice E Lyons (Address) 3135 Elmora ave

15 DEC 26 1923 Burial Permit Clerk ROBERT B. ~~KRASTEL~~ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 23 1923

17 I HEREBY CERTIFY, That I attended deceased from December 13 1923 to December 23 1923, that I last saw h~~im~~ alive on December 22, 1923, and that death occurred, on the date stated above, at 1.00 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None Byers' Examination

(Signed) Albert E Sarbaugh, M. D.

12-24-23 19 (Address) 2027 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 26 1923
20 UNDERTAKER Robt T Turner Jr	ADDRESS 1447 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82062

100-001

100 D 82062

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1117 Riggs Av. St., 16 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Edwin Hall

(Residence in Baltimore: No. 1117 Riggs Ave. St.; yrs. 5 mos. 10 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: April 5 (Month) (Day) 1923 (Year)

7-AGE: 5 yrs. 8 mos. 18 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: Lloyd Hall

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Sarah Bruce

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Hall

(Address) 1117 Riggs Av.

15- FILED DEC 26 1923 ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 23 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ch. Bronchitis

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) ....yrs. ....mos. 2 ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Dec. 24 1923 (Address) 220 Eastern Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cem. | DATE OF BURIAL: Dec 26 1923

20-UNDERTAKER: Wm. H. Johnson | ADDRESS: 416 Gay

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82063

CERTIFICATE OF DEATH.

90 D 82063

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 306 E. Lanvale ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. Rudl

(a) RESIDENCE NO. 306 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Kirk Rudl

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	83	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Peter Rudl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Sarah Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Miss Jennie Rudl

(Address) 306 E. Lanvale St

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1923, to Dec. 23, 1923,

that I last saw him alive on Dec 22, 1923,

and that death occurred, on the date stated above, at 4.20 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sup. Examination

(Signed) Geo McLean, M. D.

12/24, 1923 (Address) 1203 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Towson	Dec 26 23
20 UNDERTAKER	ADDRESS
Wm J Pickerson & Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 82064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 ✓ D 82064

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Institutions of Notre Dame 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Josephine Dietrich

(Residence in Baltimore: No. Dispatch St & Archland Ave St.; 25 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, June (Month) 9 (Day), 1871 (Year)

7-AGE, 52 yrs. 6 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country), Buffalo N.Y.

PARENTS.

10-NAME OF FATHER, Christian Dietrich

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Gremel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dismas S.S.N.D.

(Address) Dispatch St

15-

Filed....., 191.....

Registrar.

DEC 26 1923 ROBERT P. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 24th (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1923, to Dec 25 1923, that I saw her alive on Dec 24 1923, and that death occurred, on the date stated above, at 7.55 p.m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma Brain
from Medullary Carcinoma
Breast

(Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kirby M. D.

Dec 25, 1923 (Address) 110 E. Pratt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Notch Cliff	Dec 27, 1923
20-UNDERTAKER Frank A. Fink	ADDRESS 910 N. Gay St

Spec.—1-10-21—M&T—1500 Blks.

D 82065 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 82065

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 Eagle ST., 23 WARD)

2-FULL NAME Leslie M. Coombe

(a) RESIDENCE NO. 1932 Eagle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Coombe

6 DATE OF BIRTH (month, day, and year): Nov 12 1825

7 AGE: Years 75 | Months 1 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tin Shop

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Md. E. & S. Co.

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Mc Canon

(Address) 1932 Eagle St

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1923, to Dec 26, 1923, that I last saw him alive on Dec 20, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary): Ephacism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. B. Campbell, M. D.

(Address) 1044 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Dec 28, 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. North Ave.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82066

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 82066

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2048 Fountain St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Marzec

(a) Residence No. 2048 Fountain St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 13 1922

7-AGE. 1 yrs. — mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ppl

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Anthony Marzec

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Wiktorya Gabryel

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country),

14- (Informant) Mr Anthony Marzec

(Address) 2048 Fountain Street

15- Filed DEC 26 1923 ROBERT R. KRAUTH Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 25 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1923, to Dec 24 1923, that I last saw h[illegible] alive on Dec 20 1923, and that death occurred, on the date stated above, at 530A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

Dec 26, 1923 (Address) 14 So Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Stanislaus — DATE OF BURIAL. Dec. 26 1923

20-UNDERTAKER. John A. Weber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 2-23-21—E.B.R.S.—400 Bks.

D 82067

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 ✓ D 82067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1509 Lancaster St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester Swiderski

(a) Residence No. 1509 Lancaster St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 23 1923

7-AGE. X yrs. mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None ppo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country).

PARENTS.

10-NAME OF FATHER, John . Swiderski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Frances. Wenglewicz

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country). Md.

11- (Informant) Mr. John. Swiderski

(Address) 1509 Lancaster Street

13- Filed DEC 26 1923 ROBERT R. KRAUSE Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 25 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 19 23 to Dec 25 19 23

that I last saw h— alive on Dec 24 19 23

and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

(a) Malabsorption

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William A Rypins M. D.

19- (Address) 807 N Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Dec. 26 1923

20-UNDERTAKER,	ADDRESS
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82068

CERTIFICATE OF DEATH.

X | 82 D 82068

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Celia Borek

(a) RESIDENCE NO. Edgemere Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER michal Boeck

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER agatha Gerez

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr michal Boeck.
(Address) Edgemere.

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound Skull
accident

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Pilcher, M. D.
(Coroner.)

23 (Address) 145 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL 12/26 23

20 UNDERTAKER John M Weber ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-23—M&T—1500 Bks.

D 82069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 82069

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 1516 Hollins ST., 19 WARD)

2-FULL NAME Grace Durand.

(a) RESIDENCE No. 1516 Hollins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Durand.

6 DATE OF BIRTH (month, day, and year) Dec 15, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41.	—	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 039

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Edwards.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant William Durand.
(Address) 1516 Hollins St.

15 Filed DEC 26 1923 ROBERT R. KRAUSER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1. 1922, to Dec 24. 1923.

that I last saw h[illegible] alive on Dec. 23, 1923.

and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ,

Did an operation precede death? No Date of ...

Was there an autopsy? yes.

What test confirmed diagnosis? Neoplasm

(Signed) Edgar E. Graves, M. D.

, 19 (Address) 1520 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 26 1923
20 UNDERTAKER George J Smith & Co	ADDRESS 15 Holliday

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82070

HEALTH DEPARTMENT—CITY OF BALTIMORE 82070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3027 Walbrook Ave. St.; 15 WARD)

REGISTERED No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Davis

(a) RESIDENCE. No. 3027 Walbrook Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Davis

6 DATE OF BIRTH (month, day, and year) Sept 6 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Church Hill Md

PARENTS

10 NAME OF FATHER James Borton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs William J Gerbig

(Address) 3027 Walbrook Ave

15 Filed DEC 26 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-24 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3. 1924. to Dec-24 1923.

that I last saw her alive on Dec. 23 — 1923.

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease with hypertrophy and myocarditis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pericarditis.

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No — What test confirmed diagnosis? Clinical findings

(Signed) Wesley Cole, M. D.

12/24 1923 (Address) 220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forraine Cem.	Dec 27 1923
20 UNDERTAKER George J Smith & Son	ADDRESS 153 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82071

CERTIFICATE OF DEATH.

3 1

REGISTERED NO. D 82071

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Hilkens Ave. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Jennings.

(a) RESIDENCE NO. 1637 Hilkens Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 1903.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Accountant Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: B & O. R.R.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas Jennings.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Mary Logue.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Irelands

14 Informant (Address): Catherine L. Killen, 1637 Hilkens Ave.

15 Filed DEC 26 1923 ..... 19 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24" 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1922, to Dec 24, 1923.

that I last saw h[illegible] alive on " 23, 1923,

and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw V Coolahan, M. D.

12/26, 1923 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	DEC 27 1923

20 UNDERTAKER: Wm J Hartwell

ADDRESS 2254 Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82072 ✓ X 90 D 82072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp'l WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Haines

(a) RESIDENCE No. Ellicott City ST., ... WARD 4

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 30 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Haines

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Was employed for contractors

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm F. Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland—

12 MAIDEN NAME OF MOTHER Sarah Lunderstand.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Haines (Address) Ellicott City

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 25, 1923, to Dec. 24, 1923, that I last saw him alive on Dec. 24, 1923, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Infarct

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Wm F. Haines, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	Dec 26, 1923
20 UNDERTAKER	ADDRESS
Scott M. Shivers	Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21--E.B.R.S.--400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82073

CERTIFICATE OF DEATH.

90 D 82073

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 317 N. Arlington Ave. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Sullivan

(a) Residence No. 317 N. Arlington Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Sullivan

6-DATE OF BIRTH (month, day and year): May, 1853

7-AGE: 70 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Daniel Burns

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-Informant: John Sullivan Jr.

(Address): 317 N. Arlington Ave.

15-Filed DEC 26 1923

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 24, 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 29 1923 to Dec 24 1923

that I last saw her alive on Dec 24 1923

and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage
(Recurrent)

(Duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis & Valvular Heart Disease

(Duration) Unk yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Hiller M. D.

12-24 1923 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Dec. 27 1923

20-UNDERTAKER: Joseph B. Cook ADDRESS: 1003 W. Baltimore

WHITE PAPER, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

K.O.D.A. S.A.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82074

CERTIFICATE OF DEATH.

74 001 ✓ D 82074

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

2-FULL NAME George Guest

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Canmaker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 26 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 13, 19 19, to Dec. 22, 19 23, that I last saw him alive on December 22, 19 23, and that death occurred, on the date stated above, at 9:25 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Right Hemiplegia (Hemorrhage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Dorsey M. D.

12-24-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec 26 1923
20 UNDERTAKER	ADDRESS
Thos. J. G. Locke.	1302 Jefferson

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82075

CERTIFICATE OF DEATH. 185

D 82075

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Bailey

(a) RESIDENCE No 712 Central Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Gertrude ~~Bailey~~ Bailey

6 DATE OF BIRTH (month, day, and year) Apr. 10/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Griffin & Boyd

(c) Name of employer Fertilizer Mfg.

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ella Bailey

(Address) 712 Central Ave

15 Filed DEC 26 1923 192 ROBERT H. KRAMER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Fell in acid-phospha[illegible] bin. Burns on back & 2/3 of body

Acc. occured Nov 21/23

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Owen, M. D.

(Coroner)

Dec 26/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashburn Cemetery	Dec 25 1923
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	22 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation. TION is very important. See instructions on back of certificate.

Spec.—1-10 21—M&T 1500 Blks.

D 82076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 82076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3837 Clifton Ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frances Gertrude Cox.

(a) RESIDENCE No. 3837 Clifton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Cox

6 DATE OF BIRTH (month, day, and year) April 20 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John F Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth McKitty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant F E Windsor

(Address) 3402 Clifton Ave

15 Filed DEC 26 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 16 1923 to Dec. 25 1923

that I last saw her alive on Dec. 24 1923

and that death occurred, on the date stated above, at 2:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia with Pleurisy.

(duration) Y yrs. X mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) X yrs. X mos. ^ ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? Yes

What test confirmed diagnosis? "Rusty Sputum", etc.

(Signed) O. H. Hoffman, M. D.

12/25/1923 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Dec 27 1923
20 UNDERTAKER	ADDRESS
Harry N. Amacost & Son	Edgewood Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82077

CERTIFICATE OF DEATH.

D 82077

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Maryland Ave ST.; 25 WARD)

REGISTERED No. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert LeRoy Williams

(a) RESIDENCE. No. 403 Maryland Ave ST., Brooklyn WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28th 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore,

PARENTS

10 NAME OF FATHER. Robert LeRoy Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER. Bessie Hildebrandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant Mrs. Robert LeRoy Williams
(Address) 403 Maryland Ave

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 28th, 1923, to Dec 25th, 1923, that I last saw her alive on Dec. 24th, 1923, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
Premature birth

(duration) ....yrs. ....mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James R. Byrne, M. D.

(Address) 1223 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 26 1923
20 UNDERTAKER	ADDRESS
F. A. Krauer & Son	737 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82078

CERTIFICATE OF DEATH.

100-08 D 82078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Carlton St.; 24 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. ~~Zgto~~ Zgto

(Residence in Baltimore: No. 1307 Carlton St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, March (Month) 20 (Day), 1923 (Year)

7-AGE, ... yrs. 9 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Nick Zgto

11-BIRTHPLACE OF FATHER (State or Country) Austro-Hungary

12-MAIDEN NAME OF MOTHER Elisabeth Staffa

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nick Zgto

(Address) 1307 Carlton

15- Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1923, to Dec. 25 1923, that I saw h~~e~~r alive on Dec. 24 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. L. Dixon M. D.

12-26-, 1923 (Address) 801 N. Carlton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross G.G. DATE OF BURIAL, 12/26, 1923

20-UNDERTAKER Margaret S. Flynn ADDRESS 1402 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82079

CERTIFICATE OF DEATH.

99-8 01 V
99-B 82079

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 33 West North ST., 17 WARD)

2-FULL NAME Orillean Bratcher

(a) RESIDENCE NO. 33 West North ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Rye yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11-1923

7 AGE Years ... Months 2 Days 16 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur Bratcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arthur Bratcher
(Address) 33 West North Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
DEC 26 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1923, to Dec 26, 1923

that I last saw her alive on Dec 25, 1923

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Bronchitis

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Paresis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chas A Fetterhoff, M. D.

, 19 (Address) 1807 N Rutland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (?) Loudon Park C.

DATE OF BURIAL 12/27 1923

20 UNDERTAKER Wm Cooke

ADDRESS 502 E Nav

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Smoot

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82080

CERTIFICATE OF DEATH.

X 12 ✓ D 82080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Smoot

(a) RESIDENCE NO. Charlotte Hall, Maryland WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Joseph Smoot

6 DATE OF BIRTH (month, day, and year): Nov 24, 1861

7 AGE: Years 62 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Mary's Co Md

PARENTS

10 NAME OF FATHER: Julius Tippett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ann Bean

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Joseph Smoot

(Address): Charlotte Hall

15 Filed DEC 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-25 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-12, 1923, to 12-25, 1923, that I last saw h Or alive on 12-25, 1923, and that death occurred, on the date stated above, at 7:40 p.m.

The CAUSE OF DEATH* was as follows:

Acidosis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): Pancreatitis, acute

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 12-22-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & physical findings

(Signed) Henry U. P. Wilson, Jr., M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waldorf, Charles Co Md

DATE OF BURIAL: Dec 27 1923

20 UNDERTAKER: Wm. Cook for Evans Co

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82081

CERTIFICATE OF DEATH.

188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Luigi Libertini

(Residence in Baltimore: No. 1410 Ashland Ave St.; yrs. 25 mos..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, January (Month) 15th (Day) 880 (Year)

7-AGE, 43 yrs. 11 mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Agent X 08
(b) General nature of industry, business, or establishment in which employed (or employer)..... Insurance

9-BIRTHPLACE, (State or Country), Italy

PARENTS:

10-NAME OF FATHER, Joseph Libertini

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Mary Restivo.

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Libertini

(Address) 410 Ashland Ave

15-

Filed DEC 26 1923 193.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24/23 (Month) (Day) (Year) 192..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- thrown from automobile in collision.

(Inquest Dec 27/23)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Coles M. D. (Coroner.)

Dec 26/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemdm — DATE OF BURIAL, 12/27/23 19..

20-UNDERTAKER, George D. Ruth — ADDRESS 1735 Hanford Pl

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 ✓

D 82082

CERTIFICATE OF DEATH.

D 82082

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 S. Kenwood ave. ST., ✓ WARD)

2-FULL NAME James Louis Lambdin.

(a) RESIDENCE No. 1115 S. Kenwood Ave ST., ✓ WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City.
(State or country)

PARENTS

10 NAME OF FATHER James Ct. Lambdin

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Marie Rauber.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant James Ct. Lambdin
(Address) 1115 S. Kenwood Ave.

15 Filed DEC 26 1923, 19

Robert P. Harrison,
Burial Permit Clerk.
Registrar

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec - 5 - , 1923., to Dec - 24 , 1923.,

that I last saw h[illegible] alive on Dec - 5 - , 1923.,

and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Mal-nutrition

since birth (duration) yrs. 3 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. J. Davidson, M. D.

, 19 (Address) 3035 Abbottsford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Dec 26 1923.
20 UNDERTAKER Kelly & Feile	ADDRESS 403 S. Wolfe St.

Spec—12-23-21—E.P.K.S.—400 Bks.

D 82083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82083

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew Home for Aneurable 6 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ISAAC Fairbolb

(a) Residence No. 2100 E. Baltimore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Late Rebecca Feinfeld

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 66 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Hebrew 68

(b) General nature of industry, business, or establishment in which employed (or employer)..... Teacher

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant)..... Jack Lewis

(Address)..... 1439 E Balto St

15-

Filed ..... 192 Robert P. Harrison,
Registrar.

DEC 25 1923
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-26-23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1923 to Dec. 26, 1923, that I last saw h[illegible] alive on Dec. 26, 1923, and that death occurred, on the date stated above, at 12 PM m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Samuel Levine, M. D.

Dec 26, 1923 (Address) 1810 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Sanitarium

DATE OF BURIAL, 12-27, 1923

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82084

CERTIFICATE OF DEATH.

90 D 82084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 E. Front ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lyons

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 about			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Police
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Irish

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant
(Address)

15 Filed ....., 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. dis. Heart

Aortic Regurg. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. J. Riley, M. D.
(Coroner)

DEC 26, 1923 (Address) 16 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

DEC 26 1923

DEC 25 1923

THE MORGUE.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

(Courtney) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82085 ✗ 49 D 82085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hosp. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bond Courtney

(a) RESIDENCE NO. Snow Hill Md ST., WARD Snow Hill Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Courtney

6 DATE OF BIRTH (month, day, and year) Aug. 3- 873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jas Courtney

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Watson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Minnie Courtney
(Address)

15 Filed DEC 26 1923 192 Robert P. Harrison, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer Stomach (Surg. Nx)

Duration (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Dec 27, 192 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	12/27/1923
20 UNDERTAKER H C Hughes.	ADDRESS 424 N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

b 82086

HEALTH DEPARTMENT—CITY OF BALTIMORE

b 82086

CERTIFICATE OF DEATH.

100 801 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3824 Bonner Road ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida J. Tieme

(a) RESIDENCE No. 3824 Bonnor Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FeMale	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Ohrman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Matilda Ohlenroth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Ernestine Ohrman
(Address) 3824 Bonnor Road

15 Filed DEC 26 1923, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 22- 1923, to Dec 25 1923,

that I last saw her alive on Dec 24 1923,

and that death occurred, on the date stated above, at 3:45 9m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia-

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What teat confirmed diagnosis? ✓

(Signed) [illegible], M. D.

26/12/19 (Address) 125 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 12/27/23 19

20 UNDERTAKER: H. E. Hughes 424 N Broadway — ADDRESS

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82087

CERTIFICATE OF DEATH.

161-001 ✓

D 82087

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3 Altoona Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Daley

(a) Residence No. 3 Altoona Ave, St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Colored

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Colored

6-DATE OF BIRTH (month, day and year) Dec 24, 1923

7-AGE.	If LESS than 1 day,
...yrs. ...mos. 7 ds.	...hrs. or. ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Colored

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md

PARENTS.

10-NAME OF FATHER, John W. Daley

11-BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or Country) Md

12-MAIDEN NAME OF MOTHER, Jesse Wiseman

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Md

14-

(Informant) Jesse Daley

(Address) 3 Altoona Ave

15-

Filed ..... 192.. Robert P. Harrison,
Registrar.

DEC 26 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 19.23 to Dec 25 19.23

that I last saw h.. alive on Dec 25 19.23

and that death occurred, on the date stated above, at 6-30 AM

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ...Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce D. McCamant, M. D

, 19 (Address) 416 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec 27, 1923
20-UNDERTAKER.	ADDRESS
Wm Lenk & Sons	E North Ave

Instructions: Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82088

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1204 Carroll ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Klein

(a) RESIDENCE. No. 1204 Carroll St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Augusta Klein

6 DATE OF BIRTH (month, day, and year) 3-25-1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Tube Co

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augusta Klein (wife)
(Address) 1204 Caroll St

15 Filed ....., 19 Robert P. Harrison, Registrar

DEC 26 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1923, to Dec 24, 1923, that I last saw h alive on ....., 1923, and that death occurred, on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

(Address) 602 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Violetonville	12-27 1923
20 UNDERTAKER	ADDRESS
Mrs Chas A G Rohde	600 N Arlington Ave

A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&J—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82089

CERTIFICATE OF DEATH.

D 82089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3051 N. North Ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Goeller

(a) RESIDENCE No. 3051 N North Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. J Goeller

6 DATE OF BIRTH (month, day, and year) May 24 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss Eva Goeller

(Address) 3051 N North ave

15 Filed ..... 19 Robert P. Harris Registrar

DEC 26 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Dec 25, 1923, that I last saw her alive on Dec 24, 1923 and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Gall-Stones

Indefinite (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of about June 15/23

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R C Campbell, M. D.

Dec 26, 1923 (Address) 1646 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross 4946	12-28 1923
20 UNDERTAKER Ellis Harle	ADDRESS 115 E North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82090

CERTIFICATE OF DEATH.

D 82090

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14-4 1/2 St. Fairfield ST., 25 WARD)

2-FULL NAME Lizzie Woodard (C)

(a) RESIDENCE NO. 14-4 1/2 St Fairfield ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Widow.

5a If married, widowed, or ~~XXXXXX~~
~~XXXXXX~~
(or) WIFE of James Woodard. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Jackson Rainey. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Mary Byres. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Edward Rainey. (C) brother.
(Address) 14-4 1/2 St. Fairfield.

15 Filed DEC 26 1923 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) & inquest. find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound through the heart.
Homicide.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Dec, 26, 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winston Salem N. C. DATE OF BURIAL Dec. 26 1923

20 UNDERTAKER R.C Gorrell ADDRESS 210 N Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82091

101-001 ✓ D 82091

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N. Mount ST., 19 WARD)

2-FULL NAME Mary Queen

(a) RESIDENCE NO. 505 N. Mount ST., ... WARD .....

(Usual place of abode) whole life

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 19-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress for Private families

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER Virginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md.

14 Informant Irish Queen

(Address) 505 N. Mount St.

15 Filed ..... 19 .....

Robert P. Harrison,

Registrar

C 26 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24- 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22- 1923 to Dec. 24- 1923.

that I last saw her alive on Dec. 24- 1923,

and that death occurred, on the date stated above, at 11-55 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 7 da.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Chas. Ellis Corbett, M. D.

19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 27th 1923

20 UNDERTAKER A. Jones

ADDRESS 111 S. Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82092

66 D 82092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 400 N. Carlton St.

CITY OF BALTIMORE: (No. ~~Wesley Hospital~~ 4 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Hankus

(a) RESIDENCE NO. 229 Courtland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13 - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	47	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bakery Public
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 886

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Antony Hankus

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Brennagh

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary Hankus
(Address) 229 Courtland

15 Dec 26 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

C 26 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Duration (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

(Signed) W. J. Reilly, M. D.
(Coroner.)
Dec 26, 1923 (Address) 1039 Bowdoin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., 4 mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 28 1923

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1944 W. Northern

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 82093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82093

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 So. High ST., 3 WARD)

2-FULL NAME Antonio Di Bitonto

(a) RESIDENCE No. 130 So. High ST., WARD 2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Di Bitonto

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER L. DiBitonto

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER P. Mastarova

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mary Di Bitonto
(Address) 130 So. High St

15 Filed ..... 192 Robert P. Harrison, Registrar

DEC 26 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Lungs

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. H. Bridgon, M. D.
(Coroner)

Dec 26 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 27 1923

20 UNDERTAKER Wendell Dyffel Son — ADDRESS 3738

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 82094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 82094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 Fleet ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Cummings

(a) RESIDENCE NO. 1532 Fleet ST., WARD 2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cummings

6 DATE OF BIRTH (month, day, and year) Feb 3rd 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Cummings (Address) 1532 E. Fleet

15 Filed DEC 26 1923, 192 Robert F. Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo. B. Fenton, M. D.
(Coroner.)

Dec 26 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Inatitutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] DATE OF BURIAL Dec 27 1923

20 UNDERTAKER Wendell Bryll & Son ADDRESS 0781

CAUSE should be stated correctly, supplied. ADDRESS should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32095

CERTIFICATE OF DEATH.

71 D 82095

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital 5 ST., ... WARD)

2-FULL NAME Dominick Campo.

(a) RESIDENCE No. 252 N Exeter. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER Joe. Campo

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Terlando

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Italy

14 Informant Joe. Campo
(Address) 252 N. Exeter St.

15 Filed ..... 192 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

C 26 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Dec death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Questionable

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Curtis Blades, M. D.
(Coroner)

Dec 26, 1923 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cem.	Dec 27 1923

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Pneumb. &c. &c.

.....

.....

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Blks.

D 82096 **HEALTH DEPARTMENT—CITY OF BALTIMORE** X 82096 90 D 82096

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 25 (Ward)

2-FULL NAME Rev. Edward Carey C.M.

(a) RESIDENCE: (No.) St Johns College, (St.) Brooklyn, N.Y. Ward .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61 yrs				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Priest 018
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS
10 NAME OF FATHER Do not know
11 BIRTHPLACE OF FATHER (city or town) (State or country) " " "
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) " " "
(State or country) " " "

14 Informant Rev. F. Clonan C.M.
(Address) St Johns College Brooklyn N.Y.

15 DEC 27 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1923, to 12-25, 1923, that I last saw him alive on 12-25, 1923, and that death occurred, on the date stated above, at 1.20 a. m.

The CAUSE OF DEATH* was as follows:
Aortic Insufficiency
Myocardial
Chronic Myocarditis
(duration) 8 yrs. 7 mos ? ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Phys. Ex. X Ray

(Signed) H. W. Stahl M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N.Y. — DATE OF BURIAL Dec 27 1923

20 UNDERTAKER Martin Leahy & Son — ADDRESS 1827 N Howard

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82097

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ D 82097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cindrella Hopkins

(a) RESIDENCE NO. 217 S. Durham St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Duckett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Florence Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.
(Address)

15 Filed DEC 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1923

17

I HEREBY CERTIFY, That I attended deceased from December 18, 1923. to December 25 1923.

that I last saw her alive on December 25, 1923.

and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis
C.N.S Syphilis

(duration) 1 yrs. (Estimated) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G Evans, M. D.

12-26 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Ashury Cemetery	Dec 26 1923
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Eutaw

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82098

D 82098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME Ida Ramsey

(a) RESIDENCE NO. 934 W. Fed ST ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ramsey

6 DATE OF BIRTH (month, day, and year) Feb 3 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Lewis

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Johnson

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed DEC 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1923, to Dec 24, 1923, that I last saw her alive on Dec 24, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) Not known yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Peritonitis, possibly tuberculous?

(duration) 1 yrs (?) mos. ... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. R. Hannon, M. D.

12/25, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilson Station — DATE OF BURIAL Dec 28 1923

20 UNDERTAKER Dunwiddie, Co. — ADDRESS 142 Ustick St

John H. Toadvine

INFORMATION, WITH UNDERSTANDING IN REGARD TO ITEMS AND ITS PURPOSE, IS NECESSARY TO OBTAIN FULL AND ACCURATE MEDICAL AND STATISTICAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bredlove

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82099 ✓ D 82099

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 George St. Ward 11)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Bredlove.

(a) RESIDENCE. No. 647 George St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Bessie Monroe

(Address) 2031 Druid Hill Ave

15 Filed DEC 27 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1923, to Dec 25, 1923, that I last saw h.. alive on Dec 25, 1923, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ...yrs. ...mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Thos. Woolridge, M. D.

12-26 1923 (Address) 713 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lapsahanna Co.	12-28 1923
UNDERTAKER	ADDRESS
Samuel Stanley	Biddle

be stated EXACTLY. PHYSICIANS should state
be properly classified. Exact statement of OCCUPA-
of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be p
TION is very important. See instructions on back of cer

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82100

D 82100

CERTIFICATE OF DEATH.

144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Brown

(a) RESIDENCE NO. 533 Fold 2t ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Brown

6 DATE OF BIRTH (month, day, and year): May - 1896.

7 AGE: Years 27 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): ~~Johns Hopkins Hospital~~ Lancaster Co Va

PARENTS

10 NAME OF FATHER: Milton Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sally Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Johns Hopkins Hospital.

15 Filed DEC 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 24, 1923, that I last saw h alive on Dec 24, 1923, and that death occurred, on the date stated above, at 8 50 p m.

The CAUSE OF DEATH* was as follows:

Puerperal haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Separation of placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 24 1923

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) E Anderson, M. D.

12/24/1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mary Point Lancaster Co Va	12/26/1923
20 UNDERTAKER	21 ADDRESS
Samuel J Handy	Belle

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82101 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82101

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1724 N Bentelou St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Helen Dietrich

(a) Residence No. 1724 N. Bentelou St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., If of foreign birth? 54 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, ~~HUSBAND of~~ (or) WIFE of Philip Dietrich

6-DATE OF BIRTH (month, day and year) Feb 10th 1869

7-AGE, 54 yrs. 10 mos. 10 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.
10-NAME OF FATHER, John Hofmann
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mr. Ed. Barnickel
(Address) 1224 E Monument St

15-Filed DEC 27 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26 1923

17- I HEREBY CERTIFY, That I attended deceased from July 19 1922 to Dec 26 1923 that I last saw h.. alive on Dec 25 1923, at 9 o'clock A.M. and that death occurred, on the date stated above, at 1.9.. m.

The CAUSE OF DEATH* was as follows:

bronchial asthma.

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(Duration) 1 yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Hollander, M. D.
Dec 27, 1923 (Address) 1810 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore | DATE OF BURIAL, Dec 28, 1923

20-UNDERTAKER, Peter Nicolaus | ADDRESS 2060 Eastern Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Pot Tuberculosis

Cor.—1-12-23—M&T—100 Bks.

D 82102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82102

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 852 S. Eutaw St. ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unious Camphor. (C)

(a) RESIDENCE No. 852 S. Eutaw St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred --- yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 8, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Simon Camphor. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ola Cooper. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Ola Camphor (C) mother.
(Address) 852 S. Eutaw St.

15 Filed DEC 27 1923 16 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Unquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Dec, 25, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Decem 27 1923

20 UNDERTAKER: R L Parham — ADDRESS: 902 Leadenhall st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 E. Fort Ave. ST.: 24 WARD)

REGISTERED No. 89 D 82103

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Rice.

(a) RESIDENCE. No. 1338 E. Fort Ave. ST., 24. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 9 mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Bettie Rice.

6 DATE OF BIRTH (month, day, and year) March 17 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75,	9,	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B. & O. Baggageman,

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Falls Point, Md.~~ Balto. Md.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14 Informant Phillip E. Rice.
(Address) 1338 E. Fort Ave.

15 DEC 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1923, to Dec 24, 1923, that I last saw him alive on Dec 24, 1923, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hollingsworth, M. D.

12/26/1923 Address 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery, Dec.	27, 1923

20 UNDERTAKER A. Lavaud Evans. ADDRESS 1428 S. Charles ST

Cor.—1-12-23—M&T—100 Bks.

D 82104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 ✓ D 82104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 E. Lombard ST., 3 WARD)

2-FULL NAME Joseph Habrilla

(a) RESIDENCE NO. 1531 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	About 30	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 240
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dept. Eastern Dist.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 27 1923 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by the Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Hortop, M. D.
(Coroner.)

Dec 23 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional data.) Cable Line

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 192...

20 UNDERTAKER Commissioner of Health.
Per. Wm. E. WOODALL

ADDRESS DEC 26 1923

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate. at it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

Mazzofero

D 82105 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 D 82105

CERTIFICATE OF DEATH.

REGISTERED NO. 5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mazzafero

(a) RESIDENCE NO. 407 Augusta ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Peter Mazzafero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Genera Pociarelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Johns Hopkins Hospital.

Filed DEC 27 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1923, to Dec 22, 1923, that I last saw him alive on Dec 22, 1923, and that death occurred, on the date stated above, at 12 00 pm.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Induced labor for Pyelitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edelmeau, M. D.

12/23 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 26 192

Per. Wm. C. WOSSER

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

58

S. A. E. T. Y.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82106

CERTIFICATE OF DEATH.

90 D 82106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 N Eutaw ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Fritts

(a) RESIDENCE NO. 704 N Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Nicholas Rupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Laura Bug

(Address) 704 N Eutaw

15 DEC 27 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 4 1923, to Dec 26 1923.

That I last saw h.r alive on Dec 20 1923,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) J M Lampsin, M. D.

Dec 27 1923 (Address) 826 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Dec 28 1923

20 UNDERTAKER H C Fechmer & Son — ADDRESS Walbert ave

INSTRUCTIONS—This certificate must be filled in by typewriter, or with pen and ink, and must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DARK

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82107

CERTIFICATE OF DEATH.

74-001 D 82107

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 4307 Chas St ave ST., 27 WARD)

2-FULL NAME James F Moulton

(a) RESIDENCE NO 4307 Chas St ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Dallas Hamel

6 DATE OF BIRTH (month, day, and year): Dec 16 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: James F Moulton

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Clement Dutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Mrs Geo C T Moulton
(Address): 4307 Chas St ave

15 Filed ..... 192 DEC 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas H Morrissey M. D.
(Coroner)

Dec 27 1923 (Address) 1632 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: Dec 27 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1211 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82108 HEALTH DEPARTMENT—CITY OF BALTIMORE

+86-001 D 82108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Genl Hospital ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nina Waide

(a) RESIDENCE No. 329 Harlem Lane ST., Catonsville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Merrill Waide

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oakland Cal

12 MAIDEN NAME OF MOTHER Elta Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stockholm Sweden

14 Informant Merrill Waide

(Address) 329 Harlem Lane Catonsville

15 Filed DEC 27 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Dec 25, 1923,

that I last saw her alive on Dec 25, 1923,

and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) John V. Connor, M. D.

, 19 (Address) S. B. Genl Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery DATE OF BURIAL Dec 28 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Simple

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82109

CERTIFICATE OF DEATH

90 D 82109

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Mad. Ave ST., 11 WARD)

2-FULL NAME Lewis V. Lewis.

(a) RESIDENCE NO. 938 Mad. Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas W. Lewis Blk

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant W. V. Lewis
(Address) 938 Mad. Ave

15 DEC 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26th 23

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15th, 1923, to Dec. 26th 1923

that I last saw h.. alive on Dec. 24th, 1923,

and that death occurred, on the date stated above, at 10:15 A. m.

The CAUSE OF DEATH* was as follows:

a Grance Heart dis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hard work

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Fen Ellis, M. D.

12/26 1923 (Address) 724 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Dec 28 1923

20 UNDERTAKER F. A. Krause & Son

ADDRESS 703 Hanover

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82110

CERTIFICATE OF DEATH.

D 82110

1-PLACE OF DEATH 1607 North Montford Ave 8 73 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur C Neely

(a) Residence No. 1607 North Montford Ave St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, Male

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lina Neely

6-DATE OF BIRTH (month, day and year) Sept 29.1861

7-AGE, 62 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry.

(c) Name of employer Southern Laundry

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS

10-NAME OF FATHER Alexander Neely.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Martha Kinghton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-Informant Alfred S Neely

(Address) 1723 No Pulaski

15-Filed DEC 27 1923 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26.1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to Dec 26 1923 that I last saw h.. alive on Dec 26 1923 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic myelitis

(Duration) yrs. 19 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J C Lee Magness M. D

Dec 20, 1923 (Address) 1206 E Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL, 12/28 1923

20-UNDERTAKER, Williams Cook — ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82111

CERTIFICATE OF DEATH.

100-001

D 82111

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Pres. Eyer Ear Hosp. St., 24 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME James P. Kennedy.

(a) Residence No. 1331 E. Clement St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word)
Male.	White.	Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Kennedy.

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
52. yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer f/o

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael Kennedy

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Annie Hill

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Pa.

14- (Informant) Ann M. Kennedy.

(Address) 1331 Clement St

Filed DEC 27 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1923 to Dec 27 1923

that I last saw him alive on Dec 27 1923

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Frontal Sinus Operation (Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? Hospital

Did an operation precede death? yes Date of Dec 18 23

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. E. Mulcahy M.D.

12-27-1923 (Address) 322 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill.	Dec 29, 1923

20-UNDERTAKER,	ADDRESS
Leubrook & Norris E. Mark[illegible]	

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82112

D 82112

CERTIFICATE OF DEATH. — X 10

1-PLACE OF DEATH Sydenham Hosp.

CITY OF BALTIMORE: (No. 1108 E. Fayette St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Livingston

(a) RESIDENCE NO. 1108 E. Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State) Alabama

Length of residence in city or town where death occurred 0 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
mall	colrd	sigld

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 25-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Wm. Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Wm Livingston

(Address) 1104 E Fayette St

15 Filed DEC 27 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1923, to Dec 26, 1923, that I last saw him alive on Dec 24, 1923, and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria nasal, tonsilla, pharyngeal & laryngeal.

(duration) 0 yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Post diphtheritic paralysis

(duration) — yrs. — mos. 26 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures.

(Signed) B Macfarlan, M. D.

12/27/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick Cemy	Dec 27 1923
20 UNDERTAKER	**ADDRESS**
Mr - Mrs Jr S Bush	1707 N Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Forrest ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dailey

(a) RESIDENCE NO. 716 Forrest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	29	8	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER John Hailey

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Margt Kilchus

13 BIRTHPLACE OF MOTHER (city or town) Ireland. (State or country)

14 Informant Margt Hailey

(Address) 716 Forrest

15 Filed DEC 27 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/10 1923, to 12/25 1923,

that I last saw h[illegible] alive on 12/25 1923,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Howard Lowe, M. D.

Dec 26 1923 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 28 1923

20 UNDERTAKER E. A. Windsfeld Jr — ADDRESS 501 E 22 St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82114 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 1589

City of BALTIMORE: (No.) 2611 Garrison Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice S. Whiting

(a) Residence No. 2611 Garrison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: James A Whiting

6-DATE OF BIRTH (month, day and year): Oct 1853

7-AGE: 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Chas F Middleton

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary Kennedy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-INFORMANT: Mrs Alice W Mohler

(Address): Elizabethtown Ky.

DEC 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 26, 1923.

17- I HEREBY CERTIFY, That I attended deceased from Nov 5 1923 to Dec 26 1923, that I last saw him alive on Dec 25 1923, and that death occurred, on the date stated above, at 6.30 a.m. The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? St Agnes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) C Lamar Fiery, M. D.

Dec 27, 1923 (Address) 611 W. Lamar St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem — DATE OF BURIAL, Dec 29 1923

20-UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82115

CERTIFICATE OF DEATH.

90 D 82115

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2426 W. Lanvale St. WARD 16)

2-FULL NAME Margaret L. Merry

(a) RESIDENCE. No. 2426 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J. Merry.

6 DATE OF BIRTH (month, day, and year) March 17 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81 -		9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt (State or country) Md.

PARENTS

10 NAME OF FATHER Joshua Gray

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alfred E. B. Jones (Address) 2426 W Lanvale.

15 DEC 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Dec 26, 1923, that I last saw he alive on Dec 26, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Alma B Fennar, M. D.

19 (Address) 718 21 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Dec 28 1923

20 UNDERTAKER New book ADDRESS 552 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

D 82116 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 82116

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James King.

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	42	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Log Roads

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William King

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Germany

14 Informant Record of Mt Hope Retreat (Address)

15 DEC 27 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26. 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1923, to Dec. 26, 1923,

that I last saw him alive on Dec. 25, 1923,

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Paresis - Senile -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paretic Psychosis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Dec 28 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 82117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82117

188-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Penn R R at Ford Rd 24 ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johann Volkens

(a) RESIDENCE NO. 2308 Beason ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	20	-	—	

8 OCCUPATION OF DEceased
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14
Informant .....
(Address)

15 Filed ..... 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Accidental death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractures of Skull
accident

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock (Coroner)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Blades, M. D.
(Coroner)

Dec 20 1923 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health,

ADDRESS DEC 27 1923

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 82118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82118

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. D 206 Colvin St., 5 WARD)

2-FULL NAME Bessie Jones (Pillman)

(a) RESIDENCE NO. 206 Colvin St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D C
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Fred. Jones
(Address) 206 Colvin

15 Filed DEC 27 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 25 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] 1039, M. D.
(Coroner) [illegible]
DEC 26 192 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

Commissioner Health.

DEC 27 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82119

D 82119

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph McGibboney

(a) RESIDENCE No. 620 Raborg st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph McGibboney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records M.T.H.

15 DEC 27 1923 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1923, to Dec. 23, 1923, that I last saw him alive on Dec. 23, 1923, and that death occurred, on the date stated above, at 8.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. Wesbecker, M. D.

12-26-23 (Address) Municipal Tuberculosis Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 27 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

per Wm. F. Woodall

GIVE THE FULLEST MEDICAL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—2-23-21—E.B.R.S.—400 Bks.

(Roth)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82120

CERTIFICATE OF DEATH.

74-006 82120

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor, St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Roth

(a) Residence No. Preston & Valley, St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1855

7-AGE. 78 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, George Roth

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Mary Ackerman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Little Sisters of the Poor

(Address) Preston & Valley

15- Robert P. Harrison, Registrar.

DEC 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 25

17- I HEREBY CERTIFY, That I attended deceased from No record, 19..., to ..., 19...,

that I last saw h. ~~alive~~ on Dec 25 1923

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

1 week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D

Dec 25, 1923 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cem	Dec 29, 1923
20-UNDERTAKER.	**ADDRESS**
Martin Fraley & Sons	1577 N North

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter on file Dec 29-1923

D 82121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth McCauley

(a) RESIDENCE NO. St. Agnes Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1845 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
63 Forty-three	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Baltimore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Eliz" McCauley

(Address) St. Agnes Hospital

15 DEC 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1923

17

I HEREBY CERTIFY, That I attended deceased from ..., 1923, to 12-26, 1923, that I last saw her alive on 12-26, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (?)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension Cardio Renal Disease ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H V Harper, M. D.

. 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Dec 27 1923

20 UNDERTAKER Martin Fahey Son

ADDRESS 1827 N North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 82122 HEALTH DEPARTMENT—CITY OF BALTIMORE 3/ D 82122

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2231 Bank St., 1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Pural

(a) Residence No. 2231 Bank St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 15

7-AGE. 52 52 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) Poland (State or Country),

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mrs Mary Lijewski Daughter

(Address) 2231 Bank St

15- [illegible] Robert P. Harris Registrar.

DEC 27 1923

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 25/23

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Dec 20, 1923, that I last saw h[illegible] alive on Dec 15, 1923 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Many (Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin

(Signed) Samuel L Strahan, M. D

, 19 (Address) 332 S Patterson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rotary — DATE OF BURIAL: Dec 28, 1923

20-UNDERTAKER, John McAleer — ADDRESS 1803 Bank St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82123

CERTIFICATE OF DEATH.

96

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N 29th ST.: 17 WARD)

2-FULL NAME Annette Lee White

(a) RESIDENCE. NO. 109 N. 29th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Pettygrew White

6 DATE OF BIRTH (month, day, and year) Nov 28-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel J. Windsor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adeline Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr Earl Lohmeyer

(Address) 109 N-29th St.

DEC 27 1923 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1923, to Dec 26, 1923, that I last saw her alive on Dec 6, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Stokes-Adams Syndrome
(Heart block)

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ralph Lohmeyer, M. D.

12/27/1923 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	12/28-1923
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	1182 Mt Royal ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82124

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003 D 82124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Frankline Sq Hospital

CITY OF BALTIMORE: (No. 30 St., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta V. Leatherwood

(a) RESIDENCE NO. 123 S Smallwood St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos Thos. Leatherwood

6 DATE OF BIRTH (month, day, and year) Feb. 2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md. Harford Co

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Boop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Molly V. Leatherwood (Address) Hydes Baltimore Md.

15 Robert P. Harrison, Registrar

C 271923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto Accident
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock
(Duration) 1- yrs. mos. ds.

(Signed) Geo Edwin Blades, M. D.
(Coroner)

Dec 27, 1923 (Address) 1436 Poray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mission Cultivation Cemetery Carroll Co. Md. Chmel — DATE OF BURIAL 12/28 1923

20 UNDERTAKER J B. Wippert — ADDRESS 2236 Frank Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 32125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. D 32125

City of BALTIMORE: (No. 1404 Grace Court St., Curtis Bay Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie R. Lendtke

(a) Residence No. 1404 Grace Court St., Curtis Bay Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles R. Lendtke

6-DATE OF BIRTH (month, day and year) Feb 22 1875

7-AGE. 48 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, James E Toft

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Josephine Matthews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio.

11- (Informant) Charles R Lendtke

(Address) 1404 Grace Court, Curtis Bay

DEC 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 27 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1923 to Dec 27 1923

that I last saw h[illegible] alive on Dec 26 1923

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

Dec 27, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cedar Hill	Dec 29 1923
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82126

CERTIFICATE OF DEATH.

90 D 82126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Ridgely ST., 21 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Harig

(a) RESIDENCE NO. 939 Ridgely ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Harig

6 DATE OF BIRTH (month, day, and year): May 19- 1856

7 AGE — Years: 67 — Months: 7 — Days: 7 — If LESS than 1 day,....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Mayfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Harig
(Address) 939 Ridgely St

Filed DEC 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12th, 1920, to Dec 26-, 1923, that I last saw her alive on Dec 26-, 1923, and that death occurred, on the date stated above, at 1: P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C. E. Bufton, M. D.

12/27, 1923 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Dec. 28 1923

20 UNDERTAKER: Mr. & Mrs. John W. Teufel & Son — ADDRESS: 801 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82127

CERTIFICATE OF DEATH.

5 D 82127

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Furman ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Earl Smith

(a) RESIDENCE. No. 436 Furman ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Smith

6 DATE OF BIRTH (month, day, and year) June 21 - 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wilson Martin Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E. Horfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William E. Smith

(Address) 117 McHenry St

DEC 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 27, 1923, that I last saw h— alive on Dec 27, 1923, and that death occurred, on the date stated above, at 9 45 a m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis and Arthritis.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Patch, M. D.

1928 (Address) 2151 Bolton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 29 '23
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Calvert St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatoid

Arthritis 12 C/ Duration

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82128

CERTIFICATE OF DEATH.

7-881

D 82128

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1606 N. Caroline ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G Decker

(a) RESIDENCE. No. 1606 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Eicholtz

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor 016

(b) General nature of industry, business, or establishment in which employed (or employer): Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick Decker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Dietrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth E. Decker
(Address) 1606 N. Caroline St.

15 Filed . 19 ... ROBERT R. KRAUTER Registrar
DEC 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1923, to Dec 25, 1923, that I last saw h. alive on Dec 24, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of Right Side due to Cerebral Hemorrhage

(duration) — yrs. 3 mos. 25 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration Unknown) ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Jefferies Brent M. D.

12/27 1923 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	12/28 1923
20 UNDERTAKER Henry W. Mears & Son	ADDRESS 30 S. Calvert St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 ✓ D 82129

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No.... Bellevien Apts. ....4 A. ....St., 14 .....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Carrie Blankenberg.

(a) Residence No..... Bellevien Apts. 4 A. ....St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married or Divorced, (Write the word.)
Female	White	Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Blankenberg.

6-DATE OF BIRTH (month, day and year) Oct. 14, 1865.

7-AGE.	If LESS than 1 day,
58 yrs. 2 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)... None.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Baltimore,.....
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Emanuel Fleischer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Theresa Strauss.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant) Mr. Jacob Blankenberg
(Address) Bellevieu Apts. 4 A.

15- DEC 28 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 12/27/23.

17- I HEREBY CERTIFY, That I attended deceased from Jan. 23 to Dec 27 1923.

that I last saw h.. alive on Dec 27 19 23.

and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Lethargic encephalitis

.....(Duration)....yrs. 6 mos.....ds.

CONTRIBUTORY (Secondary) Myocarditis

.....(Duration)....yrs. 1 mos.....ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lentz M. D

12/27. 1923 (Address) 2040 Eutaw Place.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Baltimore Hebrew Cem.	12/28/23 19....

20-UNDERTAKER.	ADDRESS
Baird Sondheim	118-20 W. Mt. Royal Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—2-23-21—E.B.R.S.—400 Eks.

D 82130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82130

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 2956 Harford Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Scott Harry Hay

(a) Residence No. 2956 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annabell Hay.

6-DATE OF BIRTH (month, day and year) Jan. 18. 1876

7-AGE. 47 yrs. 11 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Plumbing supply

(b) General nature of industry, business, or establishment in which employed (or employer). Business

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Scott Hay.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Hanna A Heron

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Mrs. Annabell Hay

(Address) 2956 Harford Ave.

15-

DEC 28 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 26. 1923

17- I HEREBY CERTIFY, That I attended deceased from June, 1917, to Dec 26, 1923, that I last saw him alive on Dec 25, 1923, and that death occurred, on the date stated above, at 10.55 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. examination

(Signed) Geo M Lear M. D.

12/28, 1923 (Address) 1203 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL. Dec. 29, 1923

20-UNDERTAKER. Josiah Syfer. ADDRESS 1600 N. Nord Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

82131

16330 Pd

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 113 D 82131

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME John Dorsey

(a) RESIDENCE NO. Cumberland Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) May 1923

7 AGE — Years: — Months: 7 Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child pd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? .

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? .

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

DEC 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1923, to Dec 15, 1923, that I last saw him alive on Dec 15 - 1923, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. A. Beach, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS .....

DEC 27 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 82132

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Penna Ave, St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Robinson

(Residence in Baltimore: No. 909 Penna ave. St.; yrs. 55 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: about (Month) (Day) 186 (Year)

7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature, of Industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: David Harris

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Harriet Williams

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Williams

(Address) 717 Carolina St

15

Filed ..... 192 .....

Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 25 (Month) (Day) 192 3 (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, an inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) none known

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessey M. D. (Coroner.)

Dec. 27 192 3 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem DATE OF BURIAL: 12 28 23

20-UNDERTAKER: Samuel Kinsley ADDRESS: 1122 Pa

Spec– 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82133

CERTIFICATE OF DEATH.

90 D 82133

1-PLACE OF DEATH 518 North Gay St

Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bittner

(a) Residence No. 518 North Gay St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W.

5-~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Bittner

6-DATE OF BIRTH (month, day and year) Dec 12, 1854

7-AGE. 69 yrs. ..... mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER Herman Housman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Henrietta Thelman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mary Bittman

(Address) 518 N Gay St

15- Filed ..... 192....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

DEC 28 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from December 26 1923 to December 27 1923.

that I last saw her alive on December 26 1923

and that death occurred, on the date stated above, at 6 45 A. m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs *

Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) 6 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William H. Edwards M. D

12/ 27, 1923 (Address) 1200 N. Caroline St

* State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore	Dec 31 1923
20-UNDERTAKER.	**ADDRESS.**
Wm Cook	502 E Pratt Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82134

HEALTH DEPARTMENT—CITY OF BALTIMORE

89

D 82134

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1818 E. Baltimore St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JACOB CARMEL

(a) Residence No. 1818 E. Baltimore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Bella Carmel

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Louis Carmel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Hatta Solomon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 E. Balto St

15- Filed DEC 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-27-23

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26 1923 to Dec 27 1923

that I last saw him alive on Dec 27 1923

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Coronary Thrombosis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?.....

(Signed) J. William Frazier M. D.

, 19 (Address) 1407 N. Gay St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westview Memory Park — DATE OF BURIAL, 12/28, 1923

20-UNDERTAKER. Jack Levis — ADDRESS 1439 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82135

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-006 82135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Eden ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine DuBois

(a) RESIDENCE NO. 212 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lazure DuBois

6 DATE OF BIRTH (month, day, and year) — 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress & Work

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress & Work

(c) Name of employer at Home.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Myers

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Jackson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Josephine Chester

(Address) 212 N. Eden St.

15 Filed DEC 28 1923 Robert R. Krauter Registrar

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24th 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 21st, 1923, to Decbr 24, 1923, that I last saw her alive on Decbr 24, 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Influenza (duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? 212 N Eden St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) Edward Eathacompe M. D.

Dec 26, 1923 (Address) 1339 N Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Dec 28 1923

20 UNDERTAKER John C Henderson

ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82136

CERTIFICATE OF DEATH.

71-001 D 82136

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Wayland Frames M.D.

(a) RESIDENCE No. Woodbourne & Midwood ST., 27 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? 56 yrs. 3 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	M.

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Jennie W. Frames

6 DATE OF BIRTH (month, day, and year) Aug-28-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. P. Frames

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. VanMeter

13 BIRTHPLACE OF MOTHER (city or town) Phila.
(State or country) Penna.

14 Informant Mrs Jennie W. Frames-(wife)
(Address) Govans-City-

15 Filed DEC 28 1923, 19.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26-1923

17

I HEREBY CERTIFY, That I attended deceased from 12-20-, 1923, to 12-26-, 1923,

that I last saw h— alive on 12-26-, 1923,

and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis
(Staphylococcus infection)

(duration) ..yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Abscess tuberculosis (?)

(duration) ..yrs. 1 mos. ..ds.

18 Where was disease contracted if not at place of death? ww

Did an operation precede death? ww Date of

Was there an autopsy? ww

What test confirmed diagnosis? Laboratory findings

(Signed) W J Cairns, M. D.

12/30/1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 28 1923

20 UNDERTAKER STEUART & MOWEN COMPANY
(WILLIAM F. WODDEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82137

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 82137

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH City of BALTIMORE: (No. Md. Genl. Hospital St. 28th Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredericka Wendell Sommerman

(Residence in Baltimore: No. 5232 Reisterstown Rd. (28th Wd.) St.; yrs. 57 mos. 7 ds. 19.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. May (Month) 7 (Day) 1866 (Year)

7-AGE. 57 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Wendell

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Catherine E. Leland (niece)

(Address) 4706 Oakhill Ave.

15-

Filed DEC 28 1923 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 26 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Pancreatitis Hydrothorax Uremia

(Duration) 5 yrs. 6 mos. ds.

(Signed) H. Hamilton Coroner, M. D.

Dec. 28 1923 (Address) 230 Redwood St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 7 ds. In the State 57 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? ? ?

Former or usual residence 5232 Reisterstown Rd.

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec 29th 1923

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 103 W. NORTH AVE.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

82138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 82138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Blank

(a) RESIDENCE No. 1848 Divison St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of Industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Herman Blank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Saran Goodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19..... ROBERT R. KRAUTER, Registrar

DEC 28 [illegible] Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 8, 19 23, to December 27, 19 23,

that I last saw him alive on December 26, 19 23,

and that death occurred, on the date stated above, at 6:45 A. M.

The CAUSE OF DEATH* was as follows:

Syphilis

C. N. S. Syphilis (General Paresis)

(duration) 2 yrs. (Last mos.) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. Carl G. Klein, M. D.

12-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew	Dec 28, 23
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	620 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A.

Spec.—1-10-21—M&T—1500 Bks.

82139

HEALTH DEPARTMENT—CITY OF BALTIMORE

82139

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3202 Barclay ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loner Hawkins

(a) RESIDENCE NO. 3202 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dick Dickerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant C. W. Russell

(Address) 3202 Barclay St

15 Filed DEC 28 1923 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 10 1923 to Dec 27 1923.

that I last saw h alive on Dec 26 1923,

and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Chr Pul Condition

Decomposition Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Atherosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. Hawkins, M. D.

12-28 1923 (Address) 1202 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	12/29 1923
UNDERTAKER Chas. H. Johnson	ADDRESS 446 N. Carolina St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

KODAK

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 82140

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 525 S. Luzerne Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Boyer

(a) Residence No. 525 S. Luzerne Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Boyer

6-DATE OF BIRTH (month, day and year): Aug. 31, 1846

7-AGE: 77 yrs. 3 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carriage Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 15 years

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: John Boyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-

(Informant) Margaret Boyer

(Address) 525 S. Luzerne Ave

15-

Filed DEC 28 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct. 3 1923 to Dec. 26 1923

that I last saw him alive on " 26 1923

and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. A. Freez M. D.

12/27/23 (Address) 4085 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	Dec. 30 1923
20-UNDERTAKER.	ADDRESS
W. Sanders & Sons	1710 Fleet St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

3115

D 82141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 82141

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 251 S. Highland Ave 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Christian A. Berkes

(a) Residence No. 251 S. Highland Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Berkes

6-DATE OF BIRTH (month, day and year) July 9, 1853

7-AGE. 70 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Peter Berkes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Goldermann

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mary F. Untersmuth

(Address) 251 S. Highland Ave

15-

Filed DEC 28 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 26-1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1923 to Dec 26 1923

that I last saw h~~im~~er alive on Dec 26 1923

and that death occurred, on the date stated above, at 4 30 P.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

12/28 1923 (Signed) Maxwell L. Mazze M. D

(Address) 315 E Balt St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cemetery

DATE OF BURIAL. Dec 28, 1923

20-UNDERTAKER. H. Gardner & Sons

ADDRESS 1710 Fleet St.

ENDORSE CAREFULLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82142

CERTIFICATE OF DEATH.

X 30 D 82142

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp't ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Tipton

(a) RESIDENCE NO. Md. House of Correction, Jessups Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER George Tipton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Minnie Leach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Hosp. Records.
(Address)

15 Filed DEC 28 1923 19 ROBERT R. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-20 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-7, 1923, to 12-20, 1923

that I last saw h[illegible] alive on 12-20, 1923

and that death occurred, on the date stated above, at 445 p m.

The CAUSE OF DEATH* was as follows:

Actinomycosis, Intestinal
Focus began in pharynx.
Broncho-pneumonia.
about 3 mos (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes. Clinical pathology

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alleghany Co. Cemetery, Md.

DATE OF BURIAL: Dec 30 1923

UNDERTAKER: John Pearson & Son per F. P. Cowan

ADDRESS: 901-3 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82143 ✓ 101-001 ✓ D 82143

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1422 Division St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Slattery

(a) Residence No. 1422 Division St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Slattery

6-DATE OF BIRTH (month, day and year) Jan. 13-1863

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Engine Hostler

(b) General nature of industry, business, or establishment in which employed (or employer): B&O

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER, Michael Slattery

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER, Ellen Shean

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Catherine S. Slattery

(Address) 1422 Division St

15- Filed DEC 28 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 26/1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1923 to Dec 26 1923

that I last saw h[illegible] alive on Dec 26 1923

and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Chas. P. Clausius M. D.

Dec. 1923 (Address) 504 McCulloh St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL, Dec. 29. 1923

20-UNDERTAKER, H. Brauning Sons — ADDRESS 517 N. Edmondson Av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 32144

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

REGISTERED No. D 32144

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 E. Lombard ST., 3 WARD)

2-FULL NAME Edward Schultze

(a) RESIDENCE No. 1531 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	—	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Schultze

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Francis Leven

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Francis Schultze
(Address) 1531 E. Lombard St

15 Filed DEC 28 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) # yrs. # mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Norton, M. D.
(Coroner)

Dec 27 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 28 1923

20 UNDERTAKER Wm. Mora Sons ADDRESS 1737 W. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82145

CERTIFICATE OF DEATH

100-001 ✓ D 82145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen E. Kavanaugh

(a) RESIDENCE NO. 139 N. Potomac St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Municipal Hospital Records. Informant (Address)

DEC 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 1923

17

I HEREBY CERTIFY, That I attended deceased from December 19, 1923, to December 26, 1923, that I last saw him alive on December 26, 1923, and that death occurred, on the date stated above, at 7:50 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Mace, M. D.

12-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	12-28-1923
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82146

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 001 ✓ D 82146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1852 Penna Av ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Matthews

(a) RESIDENCE NO. 1852 Penna Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Bertha Matthews

6 DATE OF BIRTH (month, day, and year) June 18-1878

7 AGE 45 Years 6 Months 11 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 0440

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha Matthews (Address) 1852 Penna Ave

15 Filed ..... 16 ..... Registrar

DEC 28 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/27 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/24, 1923, to 12/27, 1923, that I last saw him alive on 12/26, 1923, and that death occurred, on the date stated above, at 2:40 A m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) B. M. Curtis, M. D.

12/27 1923 (Address) 2134 Dk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waterbury, Md Cem	12-30 1923
20 UNDERTAKER	ADDRESS
George T. A. Gibson	1735 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82147

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Williams or Howard.

(a) RESIDENCE NO. 622 Pin Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ella Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Municipal Hospital Records.

EC 281923 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 26, 19 23, to December 26 19 23, that I last saw her alive on December 26, 19 23, and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Claude F. Howard, M. D.

12-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12-31 19 23

20 UNDERTAKER Clarence E. Wright

ADDRESS 1640 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82148

CERTIFICATE OF DEATH.

161-001 D 82148

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Paca ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Thomas McLain

(Residence in Baltimore: No. 412 N. Paca St.; .....yrs., ...mos. 1 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December 26, 1923
(Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, 7 hrs. or 30 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Paul H. McLain

11-BIRTHPLACE OF FATHER (State or Country), Louisiana

12-MAIDEN NAME OF MOTHER Lillian Beatrice Wells.

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul H. McLain

(Address) 412 N. Paca

15- Robert P. Harrison, JOHNS

....., 191.....

C 281923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 26 1923, to Dec 27 1923, that I saw him alive on Dec 26 1923, and that death occurred, on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(6 months foetus)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John C. Staudburg M. D.

Dec. 27/1923 (Address) 1037 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER

ADDRESS

Commissioner Health.

DEC 28 1923

Wm. S. GOODALE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.-12-23-21—E.B.R.S.—400 Bks.

D. 82149 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 82149

CERTIFICATE OF DEATH.

84

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 S. Potomac St., 1 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James B. Adams.

(a) Residence No. 915 S. Potomac St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Percilla F. Adams

6-DATE OF BIRTH (month, day and year) Oct. 20-1840

7-AGE. 83 yrs. 2 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer). (Marine)
(c) Name of employer. Retired

9-BIRTHPLACE (city or town) (State or Country). King & Queen Co, Va.

PARENTS.

10-NAME OF FATHER, Wm L. Adams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Johanna Shackelford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14-
(Informant) Percilla F. Adams
(Address) 915 S. Potomac St

15-
Filed DEC 29 1923, 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 28-1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 16, 1923 to Dec 27, 1923
that I last saw h.. alive on Dec 27, 1923
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

Duration 3 months yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Heart

Duration ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms of Angina

(Signed) W. T. Mohler M. D.

, 19 (Address) 3015 Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oaklawn — DATE OF BURIAL. 12/30, 1923

20-UNDERTAKER. Jenkins & Pinkney — ADDRESS 1739 Eager

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82150

CERTIFICATE OF DEATH.

117 D 82150

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Thompson.

(a) RESIDENCE NO. 2407 Maryland Ave ST., WARD

(If non-resident give city or town and State)

(1)Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Thompson

6 DATE OF BIRTH (month, day, and year) May 2-1868

7 AGE Years 55 Months 7 Days 22 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railway Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Marcellus Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Emily Thompson (Address) 2407 Maryland Ave

15 Filed ....., Robert P. Harrison, Registrar

C 28 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28- 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-20-, 1923, to 12-28-, 1923, that I last saw him alive on 12-27-, 1923, and that death occurred, on the date stated above, at 6 05 A. m.

The CAUSE OF DEATH* was as follows:

Fecal Peritonitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Suppurating gangrenous Appendicitis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-20-23

Was there an autopsy? Yes.

What test confirmed diagnosis? Path. Report. —

(Signed) K. W. Gollery, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/31/19 23

20 UNDERTAKER Chas. E. Evans & Son ADDRESS 11 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

D 82151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09 D 82151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 N. Fremont ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Mills

(a) RESIDENCE NO. 304 N. Fremont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: James B. Mills

6 DATE OF BIRTH (month, day, and year): Aug 9 1855

7 AGE: Years 68; Months 4; Days 8; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Jonas Winter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Schiannow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: James B. Mills

(Address): 304 N. Fremont Ave

15 Filed ....., 19.... Robert P. Harrison Registrar

C 29 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 4 1923 to Dec. 27 1923.

that I last saw her alive on Dec. 27, 1923

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) 3 yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. K. Harris M. D.

, 19 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem

DATE OF BURIAL: Dec 29 1923

20 UNDERTAKER: Riff & Little

ADDRESS: 2288 Edmondson Av

AGE should be carefully supplied. PHYSICIANS should be stated EXACTLY. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82152 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

66 D 82152

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Jewish Hosp. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Klousmeyer.

(Residence in Baltimore: No. 15 N. Milton ave. St.; yrs. 56 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 281923

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, ~~Divorced~~. (Write word.): Married

6-DATE OF BIRTH: March (Month) 21 (Day) 1867 (Year)

7-AGE: 56 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Collector
(b) General nature of industry, business, or establishment in which employed (or employer): Fire Insurance

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Victor Klousmeyer

11-BIRTHPLACE OF FATHER (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Mary

13-BIRTHPLACE OF MOTHER (State or Country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Klousmayer

(Address) 15 N. Milton ave.

15- Robert P. Harrison,

(Filed) 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry. find that said deceased came to.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute oedema of lungs

(Duration) yrs. mos. 1 ds.

(Signed) J. F. Hennessy. M. D. (Coroner)

Dec. 29 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park. DATE OF BURIAL: Dec. 29 1923.

20-UNDERTAKER: Wendel Dippleson ADDRESS 375 Lanvale

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82153

CERTIFICATE OF DEATH.

74-09 82153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Eastern Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Williams

(a) RESIDENCE No. 2311 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Williams

6 DATE OF BIRTH (month, day, and year) Jan. 8th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER ????? Marr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W Williams

(Address) 2311 Eastern Ave

15 Filed ....., 19 .....

Robert P. Harrison, Registrar

Partial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 13, 1923, to Dec 27, 1923, that I last saw h[illegible] alive on Dec. 27, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Hamm D Hughes, M. D.

, 19 (Address) 424 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: 12/30/23

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N Broadway

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82154

CERTIFICATE OF DEATH.

90 D 82154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Sharp St. ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgia Lucia.

(a) RESIDENCE No. 225 S. Sharp St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced (or) WIFE of Frederick J. Lucia.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Massachusetts.

PARENTS

10 NAME OF FATHER ------- Morgan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Frederick J. Lucia. (husband.
(Address) 225 E. Sharp St.

15 Filed ....., 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Dec, 25, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Dec 29 1923

20 UNDERTAKER: Jas Joerdens Son — ADDRESS: 2178 Pac

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82155 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82155

CERTIFICATE OF DEATH. 1927

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 925 Hollins St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ellen Jane Cook

(Residence in Baltimore: No. 925 Hollins St.; yrs., 43 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Dec (Month) 15 (Day) 1880 (Year)

7-AGE: 23 yrs. mos. 17 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Jos E McQuinn

11-BIRTHPLACE OF FATHER, (State or Country): B C

12-MAIDEN NAME OF MOTHER: Anna Kennedy

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm Kennedy

(Address) 605 N Fremont

15- Filed DEC 29 1923 192.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or ~~Inquiry~~) thereon and from the evidence obtained by said ....(Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gallstones in Chest

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Chest suffocation by Gallstones

(Duration) ....yrs. 1 mos. ....ds.

(Signed) H K Fouche M. D. (Coroner.)

12 29 1923 (Address) 117 W Saratoga

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cemtry DATE OF BURIAL, Dec 29 1923

20-UNDERTAKER, Henry Hoelck & Sons ADDRESS 1301 Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82156 HEALTH DEPARTMENT—CITY OF BALTIMORE 1901 D 82156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced died at Mercy Hospital Registered No. C.....

City of BALTIMORE: (No. St. Helena Station Balto Co Md St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Williamina Bruerly Elphinstone

(Residence in Baltimore: No. 2703 Elsinore Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Nov 21 (Month) (Day) 1890 (Year)

7-AGE, 33 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS

10-NAME OF FATHER Wm R Bruerly

11-BIRTHPLACE OF FATHER, (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Louise J Gray

13-BIRTHPLACE OF MOTHER, (State or Country) U S A Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis M Elphinstone

(Address) 2703 Elsinore Ave

15- Filed Dec 29 1923 Robert P. Harrison Registrar.

C 29 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 27 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull and internal injuries

caused by running over Head by Penna RR. Engine

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) M Riley M. D.

(Coroner.)

Dec 29 1923 (Address) 1037 Bunny

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 29 1923

20-UNDERTAKER, Wm J Heskett Sons — ADDRESS Nor Ave & Mt Royal

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

16856 7 D 82157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 ✓ D 82157

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2—FULL NAME Martha Tate

(a) RESIDENCE NO. 1629 Aisquith St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) +

(c) Name of employer +

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Tates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 29 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 27, 1923, that I last saw h[illegible] alive on Dec 27, 1923, and that death occurred, on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
unknown etiology

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urine analysis

(Signed) H. N. Wreech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec 29 1923
20 UNDERTAKER Mrs J. S. Locks	ADDRESS 1302 Jeffery

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by state law to report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 29 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82158

CERTIFICATE OF DEATH.

3/ D 82158

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1420 E. Monument St.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sprill

(a) RESIDENCE. NO. 1420 E. Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Worker in box factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER John Sprill

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lillian Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mt. Holly

14 Informant Lillian Taylor
(Address) 1420 E. Monument

15 Filed ....., 19.. Robert P. Haverland
Registrar

DEC 29 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec 27, 1923, that I last saw h.. alive on Dec 26, 1923, and that death occurred, on the date stated above, at 7:00 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 6 yrs. ? mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Test

(Signed) W. Clyde Garnes, M. D.

Dec 27, 1923 (Address) 208 E 33

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	Dec. 30 1923

20 UNDERTAKER Jno. J. G. Locke — ADDRESS 1382 Jeffers

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement & OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 82159

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 82159

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1641 N. Carey ST.: 15 WARD)

2-FULL NAME Sarah Louise Sanders.

(a) RESIDENCE. No. 1641 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Theodore Sanders

6 DATE OF BIRTH (month, day, and year) Dec 7, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic. 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self, Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alexander Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Sarah Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City.

14 Informant Sarah E. Tabb. (Address) 1641 N. Carey St

15 Filed DEC 29 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 26, 1923, that I last saw h[illegible] alive on Dec 25, 1923, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wingfield, M. D.

Dec 27, 1923 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Dec 29th 1923

20 UNDERTAKER Thomas E. Wash ADDRESS 1364 Mary

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82160

CERTIFICATE OF DEATH.

74-021 D 82160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Mc Culloh ST., 13 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Yancy

(a) RESIDENCE NO. 2306 Mc Culloh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Yancy

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Ransom Yancy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Fannie Yancy (Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

G 29 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/23 1923 to 12/26 1923, that I last saw him alive on 12/26 1923 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
Paralysis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno R Lothrop, M. D.

12/28 1923 (Address) 213 D.A.-a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	12/30/23
20 UNDERTAKER Jas H Daniel	ADDRESS 1322

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~168818~~ D 82161 ✓ X 31 D 82161

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar James

(a) RESIDENCE NO. Corner Anna & Somerset Sts WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	9	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oscar James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lula Tilghman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 29 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1923. to Dec 26, 1923.
that I last saw him alive on Dec 26, 1923.
and that death occurred, on the date stated above, at 3.40 P. m.
The CAUSE OF DEATH* was as follows:

General miliary tuberculosis

(duration) yrs. 1 mos ? ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes. —

What test confirmed diagnosis? X-ray

(Signed) H. H. Mesh M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 12/29/23

20 UNDERTAKER Samuel S. Hemsley — ADDRESS 1778 N Caddy

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82162

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Scott

(a) Residence No. 1117 McCullough St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE: 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS:

10-NAME OF FATHER: William Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Louise Plater

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

11- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 19.. Robert P. Harrison, Registrar.

C 291023 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec. 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from November 2 1923 to December 27 1923

that I last saw her alive on December 27 1923

and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

General Metastasis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Sutton M. D

12-29-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star.

DATE OF BURIAL: 12/29 1923

20-UNDERTAKER: Samuel J. Hensley

ADDRESS 775 W. Baltimore St.

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Preston apts. Preston St., Guilford Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Hanway

(a) Residence No. Preston apts St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Rouse

6-DATE OF BIRTH (month, day and year): Apr. 12. 1840

7-AGE: 83 yrs. 8 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): Fruit Packer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Harford Co. Md

PARENTS.

10-NAME OF FATHER: Thomas Hanway

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Sarah Keene

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-

(Informant): Robert A. Rouse

(Address): 3417 Springdale Ave.

15-

Filed DEC 29 1923, Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 28/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to Dec. 28 1923

that I last saw him alive on Dec. 28 ~ 1923

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Prostate

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Metastases in liver

& intestines (Duration) yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Examination

(Signed) Julius Friedenwald M. D

, 19 (Address) 1013 St Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon Md	Dec. 30, 1923
20-UNDERTAKER.	ADDRESS
John Mitchell	1201 N. Fayette

DEC 29 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82164

CERTIFICATE OF DEATH.

D 82164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 archer St. 21 ST.; 129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Williams

(a) RESIDENCE. No. 630 archer St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	Colord	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Hattie Johnson
(Address) 630 archer St.

15 Filed DEC 29 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1923, to Dec 25, 1923, that I last saw her alive on Dec 24, 1923, and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Sterling Hogg, M. D.

12/26 1923 (Address) 712 Gwynn Oak Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION/REMOVAL	DATE OF BURIAL
Richmond Va	12.30 19
20 UNDERTAKER	ADDRESS
Daniel Easter	Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82165

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Ensor St ST., 6 WARD)

2-FULL NAME Annie E. Remmel

(a) RESIDENCE No 637 Ensor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Remmel

6 DATE OF BIRTH (month, day, and year) March, 28/1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Supplies-Orth'ics
(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins
(c) Name of employer Hospital

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Elizabeth Weisgerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine V. Mackey
(Address) 2033 N. Fulton Ave

15 Filed ..... 192 Robert P. Harrison, Registrar

12 29 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pollitt, M. D. (Coroner.)

Dec 27 23 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	12/29 192 3
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82166

CERTIFICATE OF DEATH.

90

D 82166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 555 W Lafayette ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bishop Johnson

(a) RESIDENCE NO. 555 W Lafayette ST., Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16-

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah A Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thomas Johnson

(Address) 555 W. Lafayette Ave

15 Filed ....., 19 Robert P. Harrison, Registrar

DEC 29 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1923, to Dec 28, 1923, that I last saw him alive on Dec 27, 1923 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrh

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C Stewart M. D.

, 19 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Solomons Island Md	12-30 1923
20 UNDERTAKER David Easton	ADDRESS 916 Gay st

P. S.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... that it may be properly classified. Exact statement of Occupation ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82167

CERTIFICATE OF DEATH.

161-001

D 82167

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1153 Granby St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby E Mazzo

(a) RESIDENCE. No. 1153 Granby St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 28-23

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John D Mazzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jennie Cassatino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Mazzo (Address) 1153 Granby St.

15 Filed DEC 29 1923 Robert P. Lisch Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Dec 29, 1923, that I last saw h[illegible] alive on Dec 28, 1923, and that death occurred, on the date stated above, at 4 6 m.

The CAUSE OF DEATH* was as follows:

Premature - Period of Pregnancy being about 6 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred L. Valentine M. D.

(Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

H. Funcastle — Dec 29 1923

20 UNDERTAKER — ADDRESS

Randall Lippe & Son 37 Hanover

TION is very important. See [illegible] on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 32168

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 32168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto Md

REGISTERED NO.....

CITY OF BALTIMORE: (No. 16 W Madison ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Koppelman

(a) RESIDENCE NO. 16 W Madison ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mfr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Geo. Koppelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Frauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter A Bayley
(Address) 16 W Madison St

15 Filed DEC 29 1923, 19 Robert P. Harrison, Registrar
Chief Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1923, to Dec 28, 1923, that I last saw h/ alive on Dec 28, 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

.....(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A Bayley M. D.

, 19 (Address) 16 W Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	12-30 1923
20 UNDERTAKER Henry W Justice & Sons Co	ADDRESS McCulloh Orchard

MAKE THIS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82169

(Kirchner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82169

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Patapsco ST., Westport WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emila M Kircher

(a) RESIDENCE No. 208 Patapsco ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John P. Kirchner

6 DATE OF BIRTH (month, day, and year): Sept 1-1865

7 AGE: Years 58 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Cassidy

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Lorine Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John P. Kirchner 208 Patapsco st Westport

15 Filed DEC 29 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/27, 1923, to 12/27, 1923, that I last saw h alive on 12/27, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Hurd Evans, M. D.

, 19 (Address) 1122 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Dec 31 1923

20 UNDERTAKER: Robt J Turner Jr — ADDRESS: 1452 N Broadway

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Keehner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82170

CERTIFICATE OF DEATH.

74-001 D 82170

1-PLACE OF DEATH

City of BALTIMORE: (No.) 441 N Fremont St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rosella Keehner

(a) Residence No. 441 N Fremont St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas H Keehner

6-DATE OF BIRTH (month, day and year) Feb 16, 1885

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Dorsey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Margaret Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Chas. H. Keehner

(Address) 441 N. Fremont st

15- Filed DEC 29 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 27/1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 18, 1923 to Dec 27, 1923

that I last saw h.. alive on Dec 26, 1923

and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 1 mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

12/28, 1923 (Address) 1704 N Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Westernleem — DATE OF BURIAL, Dec 31, 1923

20-UNDERTAKER, George J Smith — ADDRESS 1532 Hollins st

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82171

58-80

D 82171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ashland Ave. & 10th St., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Augusta Mason

(a) RESIDENCE NO. Ashland Ave. & 10th ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Titus L. Mason

6 DATE OF BIRTH (month, day, and year): Feb 10 1851

7 AGE — Years: 72 — Months: 10 — Days: 18 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles F. Meleher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Ann Grau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bucks Co. Penn

14 Informant: Titus L. Mason (Address): Ashland Ave. & 10th St.

15 Filed: DEC 29 1923 — Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 28, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to Dec. 28, 1923, that I last saw h alive on Dec. 27, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

1 year 2 1/2 mos.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

(Address) 13 Bel Air Rd., Roseburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: 12/31 1923

20 UNDERTAKER: Perkins & Perkins — ADDRESS: 1732 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--1-12-23—M&T—100 Bks.

D 82172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 Gough ST., 3 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathan Wheeler

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 35	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Police Dept'
(Address) Eastern Dis't JOHNS

15 Filed DEC 29 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by Inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to his death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Drunk & Fell Striking Head

(duration) yrs. mos. ds.

(Signed) John B. Horton, M. D.
(Coroner.)

Dec 26th 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or if Deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL DEC 29 1923

20 UNDERTAKER Commissioner Health,

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

DEC 29 1923

THE MORTUARY

U.S. HEALTH SERVICE

Spec– 12-23-21– E.B.R.S.– 400 Blks.

D 82173

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 82173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 802 S. Ann St., 2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances. Czyzewski

(a) Residence No. 802 S. Ann St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 24 1921

7-AGE. 2 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Stanislaus. Czyzewski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Michalina. Jankowiak

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mrs. Michalina. Czyzewski

(Address) 802 S. Ann Street

15- Dec 29 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

EC 29 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 29/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 14th 1923 to Dec 29 1923 that I last saw h.. alive on December 29 1923 and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Broncho Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Asthma & Heart Failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jay D Baldwin M. D

12/29 1923 (Address) 1623 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 31 1923

20-UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bkn.

82174

D 82174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-82174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 St Paul St or. mercy Hospital 181-001 ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Butts

(a) RESIDENCE NO. 330 St Paul ST., ... WARD .....

(Usual place of abode) Same

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of nv

6 DATE OF BIRTH (month, day, and year) July 25th 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER J. Butts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ft. Md

12 MAIDEN NAME OF MOTHER Martha Lisley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Louisa Butts
(Address) 11 N. Poplar

15 Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said By jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

a.c. Accidental

Carbon Monoxide Poisoning

Gas valve Open - Stove burning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Bailey, M. D.
(Coroner.)

DEC 27, 1923 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs., 1 mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown, Md.	Dec. 30th 1923
20 UNDERTAKER	ADDRESS
C. D. Fanning & Son	1938 E. Lafayette

Cor.—1-12-22—M&T—100 Bks.

D 82175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1152 Low St ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Asher

(a) RESIDENCE No. 1152 LOw St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Asher

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture-dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Elis Asher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Asher

(Address) 1152 Low St.

15 Filed DEC 30 1923 ROBERT R. KRAUTER, Chief Bureau of Records Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cancer of Stomach

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. A. Fuller, M. D. (Coroner.)

Dec 28/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	12/30 1923
20 UNDERTAKER A. Linton & Bro	ADDRESS 1127 E. Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82176

CERTIFICATE OF DEATH. ~~Colonial Hospital~~

D 82176

188-001

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Removed dead Mercy Hospital St.: 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Y. Feinstein

(Residence in Baltimore: No. 1010 E. Balto st. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 26 yrs. — mos. — da. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 046

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph W. Feinstein

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Binder

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph W. Feinstein
(Address) 1010 E. Balto st

15-
Filed ....., 191.... Registrar.
ROBERT R. KRAUTER
DEC 30 1923
Clerk Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock, Injuries
and internal hemorrhages
due to Shock by Struck by Auto R. R. Train
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Accident
(Duration) ....yrs. ....mos. ....ds.
(Signed) ..... M. D.
(Coroner.)
Dec 29 1923 (Address) 68 Lacy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Southern Ave	12/29 1923
20-UNDERTAKER	ADDRESS
A. Levinson & Bro	1127 Balto st

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82177

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ B 82177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2920 Parkwood ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herb Stachlas

(a) Residence No. 2920 Parkwood ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 8-1923

7-AGE. ..yrs. ..mos. 26 ds. If LESS than 1 day, ..hrs. or. ..min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) DND

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto city Md

PARENTS:

10-NAME OF FATHER, Henry Stachlas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Sarah Cohen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Henry Stachlas

(Address) Balto Md

15-

Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-29-23

17- I HEREBY CERTIFY, That I attended deceased from 12-27, 1923, to 12-29, 1923

that I last saw h[illegible] alive on 12-28 1923

and that death occurred, on the date stated above, at 11 59 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Primary)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edgar B Friedenwald, M. D.

12-30, 1923 (Address) 1616 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Mt Zion | DATE OF BURIAL, 12/31 1923

20-UNDERTAKER Jack Levis | ADDRESS 1439 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82178 — REGISTERED NO. D 82178

1-PLACE OF DEATH 1819 N. Dallas St

CITY OF BALTIMORE: (No. ____ St.: 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Roseway

(a) RESIDENCE. No. 4407 Wenwood Ave St. 27 th Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert S. Roseway

6 DATE OF BIRTH (month, day, and year) June 21. 1868

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
55	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) (State or country) Howard Co, Md

PARENTS

10 NAME OF FATHER George W. Hurvell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Mary L. Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant R. S. Roseway (Address) 4407 Wenwood Ave

15 Filed ____, 19____ Registrar

DEC 30 1923 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29 1923

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1923, to December 29, 1923, that I last saw her alive on December 28, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver and Stomach

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. D. Staufken, M. D.

Dec 29, 1923 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Dec 31 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E Hoffman

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Todd 925 N Fulton Av ✓

D 82179

HEALTH DEPARTMENT—CITY OF BALTIMORE

100.00 D 82179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 921 N. Fulton ..... St., 16 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie M. Beran (Beran)

(a) Residence No. 921 N. Fulton Av ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White.	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John M Beran

6-DATE OF BIRTH (month, day and year) Sept 1 1840

7-AGE.	If LESS than 1 day.
83 yrs. ..... mos. ..... ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Robertson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Martha Ayers.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) Miss Sadie M Beran

(Address).... 921 N. Fulton av

DEC 30 1923 ROBERT R. KRAUTER

Registrar.

Burial Permit, C. H. O.

Via · auto ·

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12 - 28 - 23

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 ..... 19 23 to Dec 28 ..... 19 23

that I last saw h[illegible] alive on Dec 28 ..... 19 23

and that death occurred, on the date stated above, at 3 p. ..... m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(primary)

(Duration) ..... yrs. ..... mos. 10 ..... ds.

CONTRIBUTORY
(Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thomas C. Wood M. D

12/29 1923 (Address) 735 N Fulton Av

State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Zion Cem.	Dec 31 ..... 19 23
20-UNDERTAKER,	ADDRESS
Lowbrook.	502 E Fayette av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82180

HEALTH DEPARTMENT—CITY OF BALTIMORE

166 D 82180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Broadway ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Burnman

(a) RESIDENCE No. 120 S. Broadway ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. News Co

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles L. Burnman

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Sweden

12 MAIDEN NAME OF MOTHER Mathilda Jensen

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Norway

14 Informant Frank L. Burnman
(Address) 1831 E. 24th St. City

15 Filed DEC 30 1923, 192.... ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28th 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide, by drinking Carbolic Acid (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. B. McMurray M. D.
(Coroner.)

Dec. 29th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 31 1923

20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 82181 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1516 W Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hattie A. Tolem

(a) Residence No. 1516 W Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles P.

6-DATE OF BIRTH (month, day and year) Nov 8-1880

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. James S Ridgely

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Susanna Rodgers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Mrs. Emma Hamsfield

(Address) 1516 W Lanvale St

15- Filed DEC 30 1923 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 28 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 19 23 to Dec 28 19 23

that I last saw her alive on Dec 28 19 23

and that death occurred, on the date stated above, at 6-30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malignant

Cachexia (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Union Mem Hosp

Did an operation precede death? yes Date of Sept 20-1923

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) John A. J. Tratand M. D.

Dec 29 1923 (Address) 1219 Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL/CREMATION/REMOVAL. Mount Carmel Ceme — DATE OF BURIAL. Dec 30 1923

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Pr St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-15—H. P. Co.—1000 Bks.

D 82182

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 ✓

D 82182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 312 N. Stricker ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flossie Webster

(a) RESIDENCE. No. 312 N. Stricker ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Ot

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. J. St Martins Phillipsburg

PARENTS

10 NAME OF FATHER John Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Martins W. J.

12 MAIDEN NAME OF MOTHER Estella Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Martins W. J.

14 Informant Mamie Desmond

(Address) 612 W. Lexington St

15 Filed DEC 30 1923 ROBERT R. KRAUTER Registrar

Daniel Pennitt, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24th, 1923, to Dec. 28th, 1923, that I last saw her alive on , 1923, and that death occurred, on the date stated above, at 8-45 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism

(duration) yrs. mos. 21 ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L. Wimmer, M. D.

12-29, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 31 1923
20 UNDERTAKER Brown & Leeland.	ADDRESS 1424 W. Lexington St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82183

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3707 Leaverton Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen M. Bodine

(a) Residence No. 3707 Leaverton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 5-1921

7-AGE. 1 yrs. 8 mos. 23 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Wm Bodine

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Anna Leonard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Wm Bodine

(Address) 3707 Leaverton Ave

15- Filed, DEC 30 1923, 192.... Burial Permit Clerk. Registrar.

HENRY H. KARSTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 28/1923

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1923 to Dec 28, 1923

that I last saw her alive on Dec 27, 1923

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

12/29, 1923 (Signed) Harvey B. Tichenor M. D.

(Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem — DATE OF BURIAL. Dec 31, 1923

20-UNDERTAKER. John Ullrich — ADDRESS 208 Aliceanna

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hilbinger

D 82184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002 D 82184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hilbinger

(a) RESIDENCE NO. Clifford Av Hamilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) Dec 24th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Walter Hilbinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mabel Vorstog

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Walter Hilbinger

(Address): Clifford Av Hamilton

15 Filed DEC 30 1923 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1923, to Dec. 29, 1923,

that I last saw him alive on Dec. 29, 1923,

and that death occurred, on the date stated above, at 11:55a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Forcep Delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Hospital.

Did an operation precede death? Forceps Date of 12-24-23.

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) J. V. Szczerbicki, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Hamilton

DATE OF BURIAL: Dec 29 1923

20 UNDERTAKER: John Ulrich

ADDRESS: 2108 Eutaw

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82185

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Pennington Ave. ST., Curtis Bay 25 WARD)

2-FULL NAME John D. Milewski.

(a) RESIDENCE No 1122 Pennington Ave. ST., Curtis Bay. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 20 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married

5a If married, widowed or divorced HUSBAND of Ursala Milewski.

6 DATE OF BIRTH (month, day, and year) Feb. 18.1878 Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saloon keeper.
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Vincent Milewski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary ---

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ursala Milewski. (wife)
(Address) 1122 Pennington Ave Curtis Bay

15 Filed DEC 30 1923 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 27, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)
Dec, 28, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	12/31/1923
UNDERTAKER	ADDRESS
Mc Farlow & Co	Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82186

CERTIFICATE OF DEATH.

100 D 82186

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Courniska

(a) Residence No. 607 S. Luzerne St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1847

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Record

(Address)

15- Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec. 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from December 18 1923 to December 28 1923

that I last saw him alive on December 28, 1923

and that death occurred, on the date stated above, at 1:50 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Drane, M. D

12-29-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Dec 30 1923
20-UNDERTAKER	ADDRESS
Fred Encoe Adm	1906 Eastlake

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

82187

101-001 ✓ D 82187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay. Gen Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry McNeir

(a) RESIDENCE NO. 122 E. Clement ST., Balto WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 11th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter 59

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Theodore W. McNeir

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Annie Shue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lillian Kelly

(Address) 122 E Clement st

15 Filed DEC 30 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28-1923

17

I HEREBY CERTIFY, That I attended deceased from 12-14-23, 19 , to 12-28-23, 19 ,

that I last saw h alive on 12-28-23, 19 ,

and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess. Post

Influenza pneumonia

Contusion

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-27-23

Was there an autopsy? No opening of Chest.

What test confirmed diagnosis? Clinical

(Signed) Geo Asperheim, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Jan 1st 1924

20 UNDERTAKER E Kleinmanbon — ADDRESS 1039 Hanover st

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82188

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 ✓

D 82188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1845 S. Charles St. St., 73 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Thomas

(a) Residence No. 1845 S. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the Word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bart. Thomas

6-DATE OF BIRTH (month, day and year) Feb. 27 1833

7-AGE. 90 yrs. 10 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Michael Engelberth

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ger.

12-MAIDEN NAME OF MOTHER: Margaret Mann

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ger.

14- (Informant): Mrs. Smith (Daughter)

(Address): 1845 S. Charles St.

15- Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 29 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1923 to Dec 29 1923

that I last saw h[illegible] alive on Dec 28 1923

and that death occurred, on the date stated above, at 1-30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Indigestion (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Dr (signed) R. R. Krauter M. D

29 1923 (Address) 1649 Eastern

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co. DATE OF BURIAL: 1/3/ 1924

20-UNDERTAKER: J. Few McCully ADDRESS: 130 E. Fort.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82189

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4132 Falls Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Morrison

(a) RESIDENCE No. 4132 Falls Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary C. Morrison

6 DATE OF BIRTH (month, day and year) Aug 23 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Asked Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Asked Not Known

12 MAIDEN NAME OF MOTHER Asked Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Asked Not Known

14 Informant Mrs Mary C Morrison

(Address) 4132 Falls Road

15 Filed DEC 30 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to Dec 26, 1923, that I last saw him alive on Dec 26, 1923, and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Chronic Myocarditis

Oedema (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) W. H. Smith, M. D.

, 19 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Dec 31 1923

20 UNDERTAKER H. S. Marshall — ADDRESS 3359 Falls Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

32190

HEALTH DEPARTMENT—CITY OF BALTIMORE

32190

CERTIFICATE OF DEATH.

99-092

1-PLACE OF DEATH 1603 Bolton ave 14

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Webster

(a) RESIDENCE No. 1603 Bolton St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? two months yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, ~~Widowed, or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: no occupation

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: John Lester Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md

12 MAIDEN NAME OF MOTHER: Susan Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant (Address): Miss Carrie Webster 1603 Bolton St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Assistant, Burial Permit Clerk.

DEC 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19th, 193., to Dec 29th, 193., that I last saw her alive on Dec 29th, 1923 and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis of many years duration

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. Sixty ds.

18 Where was disease contracted if not at place of death? Probably on life

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Amanda T. Rosser, M. D.

, 19 (Address) 110 E. 20th St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvary Md — DATE OF BURIAL: Dec 30 1923

20 UNDERTAKER: Howard K McCann — ADDRESS: Abingdon

Spec.--1-10-21--M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82191

CERTIFICATE OF DEATH.

90 D 82191

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Richwood Ave. Govans St., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Canty

(a) RESIDENCE NO. 519 Richwood Ave. Govans St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk

(State or country) Virginia

PARENTS

10 NAME OF FATHER Patrick Canty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen -----

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Leo J. Downey

(Address) 519 Richwood Ave. Govans

15 Filed DEC 30 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Dec. 28, 1923

that I last saw her alive on Dec. 28, 1923

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Mytral Regurgitation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted, if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Rumbock M. D.

12-29-1923 (Address) 15-318-Northam

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/31 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82192

CERTIFICATE OF DEATH.

44 D 82192

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1901 E. Lanvale St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georganna Maxfield

(a) Residence No. 1901 E. Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Maxfield

6-DATE OF BIRTH (month, day and year) Dec 8—1854

7-AGE. 69 yrs. — mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at Home

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

037

9-BIRTHPLACE (city or town).....
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER Daniel Schaefer

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country) Germany

12-MAIDEN NAME OF MOTHER Sarah Guyton

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country) Md.

14-Informant John H. Maxfield

(Address) 1901 E. Lanvale St.

Rec'd DEC 30 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 28-1923

17- I HEREBY CERTIFY, That I attended deceased from October 4th 1923, to Dec 28th 1923, that I last saw her alive on Dec 28th, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical X Ray.

(Signed) [illegible] M. D

12/29/1923 (Address) 401 E. 15th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Waugh Chapel Cem. | DATE OF BURIAL. 12/31, 1923

20-UNDERTAKER. Chas. H. Evans & Son | ADDRESS 118 W. Mt. Royal ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82193 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82193

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 So Linwood St., 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Grieb

(a) RESIDENCE No. 916 So. Ferdr ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Grieb

6 DATE OF BIRTH (month, day, and year) dec 2nd 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (37)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER James Egle

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Gardner

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Henry Grieb

(Address) 916 So. Ferdr St

15 Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) dec 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.

(Coroner.)

Dec 28. 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Dec. 31. 1923.

20 UNDERTAKER Lilly & Zeile

ADDRESS 403 S. Wolfe

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 82194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 16 WARD)

2-FULL NAME Edgar Leicht

(a) RESIDENCE NO. 6343 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anny Leicht.

6 DATE OF BIRTH (month, day, and year) May 9- 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Skilled

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew C. Leicht.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Emma Boehler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Anny Leicht. (Address) 122 S. 3rd St.

15 Filed DEC 30 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28th 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 28th, 1923, that I last saw him alive on Dec 28th, 1923, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal Syphilis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Wassermann.

(Signed) Clayton Watson Glen. Ferdinand, M. D.

, 19 (Address) Church Home Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem.	Dec. 31 1923
20 UNDERTAKER Lilly & Zile	ADDRESS 402 S. Wolfe St

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82195

CERTIFICATE OF DEATH.

REGISTERED NO. 66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 E. Lexington ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Donnelly.

(a) RESIDENCE NO. 710 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 6 - -1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 51 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barker 004
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Jno. Norton & Charles

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McElroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jas. Lenfert 3129 Orleans

15 Filed DEC 30 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Dom Injury (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. ds.

(Signed) W. J. Daly, M. D.
(Coroner.)

Dec 28 192 3 (Address) 1639 Ry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 12/31 192 3

20 UNDERTAKER Stonesifer & Bakes

ADDRESS 131 E. Lights St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AGE should be stated EXACTLY. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

D 82196 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 82196

CERTIFICATE OF DEATH. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Fr. Sq. Hosp. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Engelhardt

(a) RESIDENCE No. 2719 Raynor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Englehardt

6 DATE OF BIRTH (month, day, and year) March 16 1882 Century

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	9	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

075

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Paul Englehardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary J. Braden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Jennie Englehardt
(Address) Penny Cor. Pulaski & near Rolling Rd.

15 Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Dec 29 death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

2 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acc-Fall

(duration) yrs. mos. ds.

(Signed) Geo. Edwin Bates, M. D.
(Coroner)

Dec 30, 192 (Address) 1416 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn | DATE OF BURIAL Dec 31 192 3

20 UNDERTAKER Geo. N. Little | ADDRESS 35 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82197

CERTIFICATE OF DEATH.

74-001 D 82197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Warwick Ave St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Garey Kennedy

(a) RESIDENCE NO. 1629 Warwick Ave St., WARD 15
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Kennedy —

6 DATE OF BIRTH (month, day, and year) Mar. 22-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	69	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisville - Ky

PARENTS

10 NAME OF FATHER Henry Hendrickson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Garey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mr. Todd 735 N. Fulton Ave

15 Filed DEC 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1923, to Dec. 27, 1923, that I last saw h[illegible] alive on Dec. 27, 1923, and that death occurred, on the date stated above, at 4.15 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

12/28, 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Dec. 30 1923
20 UNDERTAKER W. C. Richmond Sons	ADDRESS Park Ave

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82198

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 82198

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3007 N. Calvert ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Eselmann

(a) RESIDENCE NO. 3007 N. Calvert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia Eselmann

6 DATE OF BIRTH (month, day, and year): Dec 20 1863

7 AGE: Years 60 Months 0 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Peter Eselmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Virginia Eselmann 3007 N. Calvert

15 Filed ..... 19 ..... Registrar

DEC 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 28 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15 19 23 to Dec. 27 19 23

that I last saw h alive on Dec. 27 19 23

and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 0 yrs. 2 mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. 0 mos. 8 ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Warner, M. D.

19 (Address) 700 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bellevue Md

DATE OF BURIAL: Dec 31 19 23

20 UNDERTAKER: J. Pleasants Sons

ADDRESS: Baltimore

INSTRUCTIONS—THIS STATEMENT WITH CERTIFICATE OF DEATH. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82199 X31 D 82199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME David M. Jones

(a) RESIDENCE NO. Gastonia N.C. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellamye Jones

6 DATE OF BIRTH (month, day, and year) Jan 20 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cotton Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER David S. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Madame Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 31 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1923, to Dec 30, 1923, that I last saw him alive on Dec 30, 1923, and that death occurred, on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs & genito-urinary tract.

(duration) 8 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Gastonia N.C

Did an operation precede death? yes Date of Dec 13, 1923

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) W. W. Scott M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gastonia, N.C.	Jan 1, 1924
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W. Fayette St.

IMPORTANT—THIS CERTIFICATE CONTAINS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16854 D 82200

CERTIFICATE OF DEATH.

31 D 82200

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Turner

(a) RESIDENCE NO. 115 W Lanvale ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-1923

7 AGE — Years: ..... Months: 5 Days: 16 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None - Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Recorder
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed DEC 31 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1923, to Dec 29, 1923, that I last saw him alive on Dec 29, 1923, and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

General Miliary tuberculosis

0

(duration) yrs. 1 mos ? ds.

CONTRIBUTORY (Secondary) X

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? .....

(Signed) ..... W. H. Mccl ..... M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shipman Va.

DATE OF BURIAL: 30 December 23

20 UNDERTAKER: R L Parham

ADDRESS: 902 Leadenhall

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks. 82199

D 82201 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 82201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 1032 N. Monroe St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. O'Connell

(a) Residence No. 1032 N. Monroe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE: Denis J. O'Connell

6-DATE OF BIRTH (month, day and year): June 8-1874

7-AGE: 49 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.
10-NAME OF FATHER: John Burke
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Austria
12-MAIDEN NAME OF MOTHER: Brigetta Metz
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant): Rose Messinger
(Address): 914 East Ave

15-Filed ..... 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 12-28-23

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 19 23 to Dec 28 19 23

that I last saw her alive on Dec 27 19 23

and that death occurred, on the date stated above, at 1.60 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

Arteriosclerosis

(Duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

12-28 19 23 (Address) 1000 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 31 19 23

20-UNDERTAKER: F. B. Kefferstein — ADDRESS: 1136 Fleet Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82202

CERTIFICATE OF DEATH.

1729 D 82202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 70 WARD)

2-FULL NAME Emma Burdette

(a) RESIDENCE NO. 2207 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Burdette

6 DATE OF BIRTH (month, day, and year) April 27, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. Co. Md.

PARENTS

10 NAME OF FATHER Richard Ruder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Geo. E. Burdette

(Address) 2207 Fayette St

15 Filed DEC 31 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1923, to Dec. 30, 1923, that I last saw h[illegible] alive on Dec. 30, 1923, and that death occurred, on the date stated above, at 5-10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S.S.S. + Laboratory

(Signed) Harold C. Gillaspy M. D.

Dec 30, 1923 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Jan. 2 1924

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACCURATE AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82203 46 D 82203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1516 E. Fort Ave St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret O. Connor

(a) Residence No. 1516 E. Fort Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John O Connor

6-DATE OF BIRTH (month, day and year) Sept 3, 1865

7-AGE. 58 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework. 037
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Murray

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Regan

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Edward O Connor
(Address) 1516 E. Fort Ave

15- Filed DEC 31 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). December 28 1923

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1923 to Dec. 28 1923

that I last saw her alive on Dec 27 1923

and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.
acute Dilatation of Heart
(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma Uteri.
(Duration) yrs. 3 mos. 28 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Pathological Specimen St Agnes Hospital

(Signed) Thos J. Sellers M. D

12/30, 1923 (Address) 2878 Hanford Rd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL, Dec. 31, 1923

20-UNDERTAKER, Margaret E. Flynn — ADDRESS 1422 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82204

CERTIFICATE OF DEATH.

74-001

D 82204

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Fenton ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Moore

(a) RESIDENCE No. 517 N. Fenton ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. Moore

6 DATE OF BIRTH (month, day, and year) [illegible] 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 044

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lewis Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Pindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clarence Holland

(Address) 517 N. Fenton

15 Filed DEC 31 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1923 to Dec. 29, 1923

that I last saw her alive on Dec. 29, 1923

and that death occurred, on the date stated above, at 1655 a m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorr

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

(Address) 1014 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	12-31 1923
20 UNDERTAKER John H. Tomkins	ADDRESS 142 Utica

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82205

CERTIFICATE OF DEATH.

74-001

D 82205

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N. Lyndhurst ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bode

(a) RESIDENCE. No. 421 N. Lyndhurst. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Single

6 DATE OF BIRTH (month, day, and year) June 6 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Chas W Bode.

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER C Kramer.

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14 Informant Mrs. L. Henze

(Address) 421 N. Lyndhurst St

15 Filed . 19 . Registrar

DEC 3 1923 ROBERT P. KRAUTER.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Dec 30, 1923, that I last saw her alive on Dec 29, 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis with decompensation (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Jno L. Wiesz, M. D.

, 19 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	12/24 19
20 UNDERTAKER Geo Leimbach & Son	ADDRESS 641 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Nemuras

D 82206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Registered No. C..... D 82206

1-PLACE OF DEATH

City of BALTIMORE: (No. 1016 Spence St., 25 Ward) Monument St 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Nemuras

(Residence in Baltimore: No. 1016 Spence St.; yrs. 21 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Mal	whit	Marrd

6-DATE OF BIRTH. Noknow (Month) (Day) 1874 (Year)

7-AGE. 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Talar
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Lithvania

PARENTS.

10-NAME OF FATHER. M.Nemuras

11-BIRTHPLACE OF FATHER, (State or Country). Lithvania

12-MAIDEN NAME OF MOTHER. Elezabeth Balis

13-BIRTHPLACE OF MOTHER, (State or Country). Lithvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Antanas Nemuras

(Address) 615 Washington Blvd

15-

Filed ..... 19..

ROBERT R. KRAUTER
DEC 31 1923
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 21 U.S. Dec (Month) 29 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging Suicide

(Duration) Gueldon yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) James M. Benton M. D. (Coroner.)

Dec 29, 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Dec. 31. 1923

20-UNDERTAKER,	ADDRESS
John Grebliauckas	425 S PACA St.

FILM

D 82207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

D 82207

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Estell Richardson

(Residence in Baltimore: No. 620 N Mount St St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. July (Month) 15 (Day) 1919 (Year)

7-AGE.	If LESS than 1 day,
4 yrs. 5 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Salt Lake City

PARENTS.

10-NAME OF FATHER, Richardson

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Richardson

(Address) 620 N Mount St

15-

FILED DEC 31 1923 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st Burns over L. Chest

Due to Burning

with Matches

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) Septic Intoxication

(Duration) ....yrs. ....mos. 2

(Signed) James M. Renton M. (Coroner.)

Dec 29 1923 (Address) 7 St Paul

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Pleasant Cem	12-31 1923
20-UNDERTAKER.	ADDRESS
David Easton	916 Penna av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U.S.A. DAKIN

Cor.—1-12-23—M&T—100 Bks.

D 82208

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 82208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 8 WARD)

Charles & Mt. Lean (Mt. Lean)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME .....

(a) RESIDENCE No. 1219 N. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3, 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Geo McLean

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) S. C.

12 MAIDEN NAME OF MOTHER Margt Kennedy

13 BIRTHPLACE OF MOTHER (city or town) S. C. (State or country)

14 Informant Geo. McLean Father (Address) 1219 Bond

15 Filed ..... 192 ..... Registrar

DEC 21 1923 ROBERT R. KRAUTER Clerk Permit Office

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism with Nephritis

(Duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

(Signed) W. J. Riley, M. D.

(Coroner.)

Dec 31, 1923 (Address) 1639 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 1/2 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82209

REGISTERED NO. 6280

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital Tuberculosis Hosp. ST., 8 WARD)

2-FULL NAME Daniel Graiser

(a) RESIDENCE No. 1838 N. Bethel St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Barbara Graiser

6 DATE OF BIRTH (month, day, and year) 1/12/1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	"			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Graiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Fallerina Kilnear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wife. Barbara Graiser 1838 N. Bethel St.

15 Filed DEC 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1923, to Dec 30, 1923, that I last saw him alive on Dec 30, 1923, and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum. Haemoptsis

(Signed) Lawrence Selt, M. D.

(Address) Municipal Hospo.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 1/3 1924

UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82210

CERTIFICATE OF DEATH.

159-002 D 82210

8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 N. Regester ST., WARD)

2-FULL NAME Charles William Doll

(a) RESIDENCE NO. 1520 N. Regester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unmarried

6 DATE OF BIRTH (month, day, and year) Dec 27 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore Maryland (State or country)

PARENTS

10 NAME OF FATHER Charles F. Doll

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Goodwin

13 BIRTHPLACE OF MOTHER (city or town) Balt. (State or country) Md.

14 Informant Carrie T. B. Doll

(Address) 1520 N. Regester

15 Filed DEC 31 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1923, to Dec 27 1923, that I last saw him alive on Dec 26 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) non closure foramen Ovale (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

12-29-1923 (Address) 1514 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 12/31/1923

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82211

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-091 D 82211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 864 W Lanvert ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Comley

(a) RESIDENCE NO. 864 W. Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Martha Comley

6 DATE OF BIRTH (month, day, and year): [illegible] 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 086

(b) General nature of industry, business, or establishment in which employed (or employer): Church

(c) Name of employer: Rev Pitcher

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Martha Comley

(Address): 864 W. Lombard St

DEC 31 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/30/1923

17 I HEREBY CERTIFY, That I attended deceased from 12/26/, 1923, to 12/30/23, 1923,

that I last saw him alive on 12/27/23, 19.....,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Chr. Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Contributory unknown

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Emmett Finn, M. D.

12/30 19 23 (Address) 710 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec 31 1923
20 UNDERTAKER	ADDRESS
Wm E. Miller	2334 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1923
1845
78

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82212

CERTIFICATE OF DEATH.

D 82212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4900 Harford Road ST., Laurville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Sack (Sack)

(a) RESIDENCE No. 4900 Harford Road ST., Laurville WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER G. C. Adam Sack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna B. Kubel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ellsworth Miller (Address) 4900 Harford Road

15 DEC 31 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Dec 29, 1923, that I last saw him alive on Dec 28, 1923, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Henry W. Long, M. D.

(Address) 27 N. Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Dec. 31, 1923
20 UNDERTAKER	ADDRESS
Fred'k Lauraston & Son	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32213

CERTIFICATE OF DEATH.

24-001

D 32213

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 509 Archer St. St.: 21 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nannie M. Eichler

(Residence in Baltimore: No. 509 Archer St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, May 9, 1869
(Month) (Day) (Year)

7-AGE, 54 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Melchior J. Armacost

11-BIRTHPLACE OF FATHER (State or Country), Don't Know.

12-MAIDEN NAME OF MOTHER Eliz. Russell

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William E. Eichler

(Address) 509 Archer St.

15-

Filed DEC 31 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix

Duration 1 yrs. mos. ds.

(Signed) James M. Benton M. D.
(Coroner.)

Dec. 28 1923 (Address) 2615 Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Dec 31, 1923

20-UNDERTAKER	ADDRESS
Mr & Mrs. John M. Teufel & Son	801 W. Fayette

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82214

CERTIFICATE OF DEATH.

90

D 82214

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 W. Cross ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Macher

(a) RESIDENCE NO. 612 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of William Macher.

6 DATE OF BIRTH (month, day, and year) Nov. 6. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Rusel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Macher

(Address) 612 W. Cross st.

15 Filed DEC 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 13, 1923, to Dec 27, 1923, that I last saw her alive on Dec 27, 1923, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J M Lampden, M. D.

Dec. 27 1923 (Address) 826 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec. 31 1923

20 UNDERTAKER Mr & Mrs. John H. Teufel & Son

ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82215

CERTIFICATE OF DEATH.

V 74-09 D 82215

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE, (No. 1540 Pennsylvania Ave. WARD 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Schofield

(a) RESIDENCE NO. 1540 Pennsylvania Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Schofield

6 DATE OF BIRTH (month, day, and year) Jan 16 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) at

(c) Name of employer Health Dept.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co. Md.

14 Informant Bertha Schofield (Address) 1540 Pennsylvania Ave

15 Filed DEC 31 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 30, 1923, that I last saw him alive on Dec 30, 1923, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) James Brown M. D.

12/31, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Ridge Cemetery	Jan. 2. 1924
20 UNDERTAKER	ADDRESS
Mr & Mrs John H. Teufel & Son	824 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82216

CERTIFICATE OF DEATH.

D 82216

REGISTERED NO. 1627

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4916 Park Heights Av ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Alexander Brooks

(a) RESIDENCE. No. 4916 Park Heights Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Maurice Alx Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elsie V Burall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mauric A Brooks
(Address) 4916 Pk Hts Av

15 Filed DEC 3 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Dec 30, 1923, that I last saw him alive on Dec 30, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Meningeal Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemophilia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) W H Cooper M D, M. D.

12/30/23 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Jan 1 1924

20 UNDERTAKER W. M. Kinton

ADDRESS 2235 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82217

CERTIFICATE OF DEATH.

47

D 82217

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 W. North ave ST.: 15 WARD)

2-FULL NAME Helene Picker

(a) RESIDENCE. No 2228 W. North Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of Kunibert Picker

6 DATE OF BIRTH (month, day, and year) May 28-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	57	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Bokel.
(State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Bikrichman

11 BIRTHPLACE OF FATHER (city or town) Bokel
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) Germany.

14 Informant Kunibert Picker.
(Address) 2228 W. North Ave

15 Filed DEC 31 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29- 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7 — , 1923. to Dec. 29 — , 1923.

that I last saw h.. alive on Dec. 28 — , 1923.

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation —
(Hypertrophy for several years)
Thrombosis, Right femoral vein
(duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) Carcinoma Breast.
(duration) — yrs. 6+9 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Nov. 26-1923

Was there an autopsy? no — eyes

What test confirmed diagnosis? microsc. exam Carcinoma

(Signed) J. Bourdillon Bittner M. D.

12/27/1923 (Address) 212 S. Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel Cemetery

DATE OF BURIAL: Jan 1 1924

20 UNDERTAKER: H. M. Routson

ADDRESS 2230 W North.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001 D 82218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 S. Parrish ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Bell

(a) RESIDENCE No. 424 S. Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The Late George W. A. Bell

6 DATE OF BIRTH (month, day, and year) Oct 11, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER [illegible]. A. Prince

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George E. Bell

(Address) Curtis Bay, City.

15 Filed ..... 19 ..... Registrar

DEC 31 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1923

17

I HEREBY CERTIFY, That I attended deceased from December 20, 1923 to December 28, 1923

that I last saw her alive on " " , 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (5 yrs.)

Broncho-pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D.

12/31 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Dec 31 1923
20 UNDERTAKER Harry H. Witzke	ADDRESS 1531 W. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82219

CERTIFICATE OF DEATH.

161-001 D 82219

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #3 Parkwood ST.; No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Driscoll

(Residence in Baltimore: No. #3 Parkwood St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, Dec. (Month) 30 (Day), 1923 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 2 hrs. or ....mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Edw. Driscoll

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mary Dietrich

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Driscoll

(Address) 3 Parkwood Road

15-

Filed DEC 31 1923 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30 1923, to Dec 30 1923, that I saw him alive on Dec. 30 1923, and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

7 mos.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs....mos....ds.

(Signed) Lyman S. abbott M. D.

Dec 30, 1923. (Address) 1832 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Dec 31, 1923

20-UNDERTAKER Harry H. Witzke

ADDRESS 1531 W. Lombard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82220

CERTIFICATE OF DEATH.

129 D 82220

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 S. Parrish St., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence M. Clazey

(a) RESIDENCE NO. 306 S. Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Clazey

6 DATE OF BIRTH (month, day, and year) [illegible]ar 5 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William F. Ely

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Collett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Harry Clazey
(Address) 306 S. Parrish St.

15 Filed DEC 31 1923 19 ROBERT R. KRAUTER Registrar
DEC 31 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/29/1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 23 to Dec 29, 19 23,
that I last saw h alive on Dec 29, 19 23,
and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Oedema

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dreen M. D.

, 19 (Address) 1227 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 31 1923
20 UNDERTAKER	ADDRESS
Harry H. Witzke	521 W. Lombard St

N. B.—MARK PLAINLY, WITH INKING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82221

CERTIFICATE OF DEATH.

129 D 82221

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 27 WARD)

2-FULL NAME Mrs. Pearl Lieberman

(a) RESIDENCE NO. 700 Woodland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karl Leherman

6 DATE OF BIRTH (month, day, and year) Nov 11 - 1908

7 AGE Years 25 Months — Days — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Moses Selman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Etta Kaplan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto St

15 Filed DEC 3 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1923, to Dec 31, 1923, that I last saw h alive on Dec 31 1923, and that death occurred, on the date stated above, at 1:25 a m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Stuber Landsman M. D.

, 19 (Address) Hebrew Hosp 12/24/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehsen Rosedale — DATE OF BURIAL Dec 31 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82222

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

CERTIFICATE OF DEATH.

D 82222

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 801 Sterling Street 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jonas Kirshman

(a) Residence No. 801 Sterling Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ada Kirshman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balt St

15-

Filed ..... 192.... ROBERT P. KRAUTER

Registrar.

Burial Permit Clerk

DEC 31 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12/30/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1923, to Dec 30, 1923,

that I last saw him alive on Dec 30, 1923,

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

Myocarditis

from increasing age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Smith M. D.

19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mehrlen Rosedale	12/31, 19 23
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Balt St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

82223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 936 Whitlock St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Abraham J. Cordish

(a) Residence No. 936 Whitlock St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

~~Single,~~ Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rachael Cordish

6-DATE OF BIRTH (month, day and year) unknown

7-AGE 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired merchant

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Zalman D. Cordish

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant)... D. Cordish

(Address) 4012 Springdale Ave

15- Filed....., 192.... ROBERT P. KRAUSE, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 12-30-23

17- I HEREBY CERTIFY, That I attended deceased from May 1 1923 to Dec 30 1923 that I last saw him alive on Dec 30 1923 and that death occurred, on the date stated above, at 8.15 p. m. The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Exploratory

(Signed) Benj. V. Cadow M. D.

, 19 (Address) 2306 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale — DATE OF BURIAL, 12/31/... 1923

20-UNDERTAKER. Jack Levin — ADDRESS 1439 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82224

CERTIFICATE OF DEATH.

162 D 82224

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 925 S. Linwood Ave. St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur E. Hanes

(a) Residence No. 925 S. Linwood Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 19, 1923

7-AGE. .....yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Philip Hanes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Minnie Schoenfelder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-

(Informant) Mr. Philip Hanes

(Address) 925 S. Linwood Ave.

15-

Filed DEC 31 1923 19.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 30, 1923

I HEREBY CERTIFY, That I attended deceased from Dec 20 19 23 to Dec 30 19 23

that I last saw h[illegible] alive on Dec 29 19 23

and that death occurred, on the date stated above, at 4 00 A. m,

The CAUSE OF DEATH* was as follows:

Atelectasis Congenital

.....(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary)

.....(Duration)....yrs....mos....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) A M Tilton M. D

12/30 1923 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cemetery	Jan 1 1924
20-UNDERTAKER.	ADDRESS
H. Gander & Sons	1710 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82225

CERTIFICATE OF DEATH.

46 D 82225

1-PLACE OF DEATH 704 Ensor St

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Hopkins

(a) RESIDENCE NO. Glyndon Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hopkins

6 DATE OF BIRTH (month, day, and year) Oct - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Halifax Co Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant J Hopkins
(Address) Glyndon Md

15 DEC 31 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-12-1923 to 12-29 1923

that I last saw her alive on 12-29 1923

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Leakage of Heart and Carcinoma of Uterus

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Leakage of Heart

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) D. E. Kennard, M. D.

, 19 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[redacted] Cemetery	Jan 1 1924
20 UNDERTAKER J F Edris	ADDRESS Reisterstown

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 82226

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2206 Eager Place ST., 7 WARD)

2-FULL NAME Frances Wolf

(a) RESIDENCE No. 2206 Eager Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wolf

6 DATE OF BIRTH (month, day, and year) June 3rd 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER C. Noce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie Neubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lizzie Noce
(Address) 2206 Eager Place

15 DEC 31 1923 ROBERT R. KRAUTER Clerk Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-26 1923 to 12-29 1923

that I last saw her alive on 12-29 1923

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Glaucoma

(duration) yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) F. Fred Bunn M. D.

19 (Address) 800 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 2" 1924
20 UNDERTAKER Geo W. Fink & Son	ADDRESS 811 N Carey

N. B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

82227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 82227

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 424 S Fifth St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Eveard

(a) Residence No. 638 S 15th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lenard Eveard

6-DATE OF BIRTH (month, day and year) October 20 1890

7-AGE, 33 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Ray

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Storch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Wm Ray

(Address) 638 S 15th St

15- Filed DEC 3 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) December 30 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 1- 23 to Dec 28- 23

that I last saw her alive on Dec 28 23

and that death occurred, on the date stated above, at 12/45 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

.....

.....

.....(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) none.

.....(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H Herrman M. D.

12-31-23 (Address) 1919 E Balto St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: January 2 1924

20-UNDERTAKER: Wendell Oppel & Son — ADDRESS: 37 S Mar

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82228

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-001 ✓

59 D 82228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 20 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Unger.

(a) RESIDENCE No. St Agnes Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/28/23.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Infant.			4 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Agnes Hosp
(State or country)

PARENTS

10 NAME OF FATHER Geo. Unger

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Sophie Mentzer

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) " Md

14 Informant Mr George Unger
(Address) 2432 Frederick Ave

15 DEC 31 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-28-, 1923, to 12-28, 1923,

that I last saw h alive on 12-28, 1923,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital hydrocephalus

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) M. Alexander Novey M. D.

12/28, 1923 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec: 31, 1923
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Frederick Ave.

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

b 82229

1447 82229

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 6 WARD)

2-FULL NAME Lessa Foster

(a) RESIDENCE No. 110 Dallas St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) Farmville Va
(State or country)

PARENTS

10 NAME OF FATHER George Foster

11 BIRTHPLACE OF FATHER (city or town) Farmville
(State or country) Va

12 MAIDEN NAME OF MOTHER Mattie Brown 12-31-1923

13 BIRTHPLACE OF MOTHER (city or town) Farmville
(State or country) Va

14 Informant .....
(Address) UNIVERSITY OF MARYLAND.

15 Filed DEC 31 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

393

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1923

17 I HEREBY CERTIFY, That I attended deceased from December 14 1923 to December 24, 1923, that I last saw h[illegible] alive on December 24, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Post-Partum Hemorrage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute exacerbation of Chronic Pelvic inflamatory Disease.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Midforceps Date of Dec 15, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings, Autopsy

(Signed) Louis A. Douglass, M. D.

(Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

DEC 31

Commissioner Health,

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of SCARLET FEVER, DIPHTHERIA, TUBERCULOSIS, CANCER, MALIGNANT TUMOR, CHILDBIRTH, ABORTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82230 — 100-001 — D 82230

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Long or Lang

(a) RESIDENCE. NO. Bay View Asylum ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Municipal Hospital Records
(Address)

15 Filed DEC 31 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1922 to December 26, 1923, that I last saw him alive on December 25, 1923, and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude F Dixon, M. D.

12-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: DEC 31 1923

20 UNDERTAKER: Commissioner Health. — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82231

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 E 20 St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Jane H Bees

(a) RESIDENCE. No. 704 E 20th St ST., WARD. 9th

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin L. Bees

6 DATE OF BIRTH (month, day, and year): June 12th 1873

7 AGE: Years 50 Months 6 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Hanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Martin L Bees (Address) 704 E 20th St

15 Filed [illegible] 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

DEC 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1923, to Dec 30, 1923 that I last saw h[illegible] alive on Dec 30, 1923, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 20 days

CONTRIBUTORY (Secondary) Nephritis,

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Young, M. D.

, 19 (Address) 4142 North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 2 1924

20 UNDERTAKER: E. A. Windfield Jr — ADDRESS: 511 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Foot of Clinton ST., 17 WARD)

REGISTERED NO. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Wetzel

(a) RESIDENCE NO. 2310 Green mount ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Wetzel

6 DATE OF BIRTH (month, day, and year) abt Dec 20 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mid City Garage

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Wetzel
(Address) 2310 Green Mount Ave

15 Filed DEC 31 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning -
Down Automobile overboard
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pier foot of Clinton St.
(Duration) yrs. mos. ds.

(Signed) Thos. B. Morton, M. D.
(Coroner.)
Dec 30th, 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary Cem. Govans	Jan 2 1924
20 UNDERTAKER E. A. Widefield Jr	ADDRESS 501 E 22d

MEDICAL EXAMINER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.- 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1680 D 82233 — CERTIFICATE OF DEATH. — X 90 D 82233

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Bowman

(a) RESIDENCE NO. Branchville S C ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — ?

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Daniel Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Clara Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..., 19 ... Registrar

Robert P. Harrison, Burial Permit Clerk.

DEC 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1923, to Dec 29, 1923 that I last saw h[illegible] alive on Dec 29, 1923, 10 45 a.m. and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Myocardial insufficiency

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T.R. Hannon, M. D.

12/31, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Branchville S.C.	Dec 31 1923
20 UNDERTAKER	ADDRESS
Joseph Abrams	221 B Way

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82234

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 531 N. Rose ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig Grill

(a) RESIDENCE NO. 531 N. Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Theresa Grill

6 DATE OF BIRTH (month, day, and year) June 17/62

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet 814

(b) General nature of industry, business, or establishment in which employed (or employer) Maker

(c) Name of employer National Casket Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. Grill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa Grill

(Address) 531 N. Rose St

15 DEC 31 1923 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1923, to Dec. 30. 1923.

that I last saw him alive on Dec 30. 1923

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Bright's disease

Uraemic Convulsions

(duration) — yrs. 10 mos. 3 ds.

CONTRIBUTORY (Secondary) Bright's disease

(duration) — yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Albumen in the urine.

(Signed) F. J. Sebald, M. D.

, 19 (Address) 1001 Argyle Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 2 1923

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

168622 Pd 82235

CERTIFICATE OF DEATH.

159-09 D 82235

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

2-FULL NAME Rita Gamble

(a) RESIDENCE NO. 202 Fullen Rd ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER August

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... Registrar Robert P. Harrison,
Burial Permit Clerk.

N 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Dec 31, 1923, that I last saw her alive on Dec 31 —, 1923, and that death occurred, on the date stated above, at 6 10 a m.

The CAUSE OF DEATH* was as follows:

Congenital atresia of esophagus.

5 yrs 5 mos ds. (duration)

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Dec. 29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Mixter, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill - Towson	Jan 1 1923
20 UNDERTAKER	ADDRESS
Mrs. Mrs. John W. Teufel & Son	801 W. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 X 90

D 82236

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 5 E Pleasant St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Julius Hall

(a) Residence No. 5 E Pleasant St., Ward Annapolis Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mail

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Bankkeeper

(b) General nature of industry, business, or establishment in which employed (or employer). Retired 08

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, E. C. Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Annapolis Md.

(Address) H. C. Taylor.

15- Filed JAN 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/1/24

17- I HEREBY CERTIFY, That I attended deceased from 12/21 19 23 to 1/1 19 24

that I last saw him alive on 12/23 19 23

and that death occurred, on the date stated above, at 2 15 9 m.

The CAUSE OF DEATH* was as follows:

Coma — insufficiency

probably 1 year

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema 1/2 Lung

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. C. Taylor M. D.

1/6/24. 19 (Address) 1403 Bonaire

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Annapolis Md. DATE OF BURIAL. Jan 3, 1924

20-UNDERTAKER. Taylor & Sons. ADDRESS Annapolis Md.

IMPORTANT: This RECORD is PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1122 N. Mount ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Louis Axt

(a) RESIDENCE NO. 1762 Garrison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie R. Axt

6 DATE OF BIRTH (month, day, and year): Dec 16 1866

7 AGE: Years 57. Months 0 Days 15. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto city Md.

PARENTS

10 NAME OF FATHER: Martin Axt.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Fredericka Ebert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Minnie Burgan, 1762 Garrison Ave.

15 Filed ....., 19.... Robert P. Harrison, Registrar

JAN 1 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Dec. 31, 1923, that I last saw him alive on Dec 30, 1923; and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) few hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebroma (duration) 1 yr mos. ds.

(over)

18 Where was disease contracted if not at place of death? 1

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) V. P. Robinson, M. D.

1/2/1924 (Address) 1122 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery. DATE OF BURIAL: 1/2. 1924

20 UNDERTAKER: J. Walter Davis ADDRESS: 330 Paine St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82238

CERTIFICATE OF DEATH.

31

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 E. Baltimore St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Herling

(Residence in Baltimore: No. 726 E. Balto st

St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Dec 31, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
48 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Restaurant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Herling

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Mollie Goldstein

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Herling

(Address) 3417 Holmes Ave.

15-

Filed ....., 191.....

Registrar.

Robert F. Harrison,
Clerk.

JAN 1 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholic Gastritis

Dont yard

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

Lung (Duration) yrs. mos. ds.

(Signed) W. T. Ruby M. D.
(Coroner.)

Dec 31, 1923 (Address) 1039 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, Jan. 1, 1924

20-UNDERTAKER L. Levinson & Bro

ADDRESS 1127 E Balto st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.-1-30-21 M&T 1500 Blks.

16 96 D 82239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 160

CITY OF BALTIMORE: (NO. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Thompson

(a) RESIDENCE NO. 1701 Presstbury ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 24-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. Anson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mable Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JAN 1 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Dec 29, 1923, that I last saw h[illegible] alive on Dec 29, 1923, and that death occurred, on the date stated above, at 7 10 P. m.

The CAUSE OF DEATH* was as follows:

Anemia (Undetermined Origin)

?
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis & Hemorrhage
(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? 0

(Signed) H. N. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL 1-1-1924

20 UNDERTAKER David Garson

ADDRESS 916 Penna Ave

Robert P. Jackson
Burial Permit Clerk

INK—THIS IS A PERMANENT RECORD. Every ... of information should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This baby was a very much undernourished. Malnutrition - the

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2230 Fleet St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank . Mazerski

(a) Residence No. 2230 Fleet St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 24 1923

7-AGE. ...yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Wicent Mazerski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Maryanna . Sroka

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-

(Informant): Mr Vincent . Mazerski

(Address): 2230 Fleet Street

15-

Filed JAN 1 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Dec 31 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 29 19 23 to Dec 31 19 23

that I last saw h... alive on Dec 31 19 23

and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William D. Ryan M. D

1924 (Address) 824 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL, Jan 1 1924

20-UNDERTAKER: John A. Weber

ADDRESS 1803 Bank St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pds.

D 82241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82241

CERTIFICATE OF DEATH.

15 90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1714 Ellamont St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Eldridge

(a) Residence No. 1714 Ellamont St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cetra Bennett

6-DATE OF BIRTH (month, day and year) Nov 29, 1848

7-AGE. 75 yrs. 1 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. retired

(b) General nature of industry, business, or establishment in which employed (or employer). Agent sewing Machine

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Robert L. Eldridge

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N. J.

12-MAIDEN NAME OF MOTHER. Emeline Carling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N. Y.

(Informant) Kate E Eldridge

(Address) 1714 Ellamont St

15-

Filed JAN 7 - 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31/23

17) I HEREBY CERTIFY, That I attended deceased from Jan 1 — 1923 to Dec 31 — 1923

that I last saw him alive on Dec 19 — 1923

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with myocardial degeneration

(Duration) 2 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Harvey Cox, M. D.

12/31/23 (Address) 2702 Johnson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Ver — DATE OF BURIAL, Jany 2, 1923

20-UNDERTAKER, John C Mitchell ADDRESS 1501 W Fayette St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A. KODAK

Spec.—1-10-21—M&T—1500 Bks.

D 82242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82242

CERTIFICATE OF DEATH.

17

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Topkins

(a) RESIDENCE NO. 1015 N. Carroll Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Blk	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

JAN 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Decemb. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Novemb. 4, 1923, to Decemb. 30, 1923, that I last saw her alive on Decemb. 29, 1923, and that death occurred, on the date stated above, at 7.20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Syphilitis

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tern. Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinic & Laboratory

(Signed) H. Grimm, M. D.

12/31/1923 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Bonly Wks. King & Queen Co. Va.

DATE OF BURIAL Jan 2 1924

20 UNDERTAKER Sam'l N. Chase & Son

ADDRESS 1400 M. Ave

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

McCleary
1609 Linden

D 82243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2736 St Paul 17 90 Registered No.....

City of BALTIMORE: (No. 2736 St Paul St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Lynch

(a) Residence No. 2736 St Paul St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-Single, Married, Widowed, or Divorced (Write the word.) Widower

5-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Francis R

6-DATE OF BIRTH (month, day and year) Sept 19-1831

7-AGE. 92 yrs. 3 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Sept
(b) General nature of industry, business, or establishment in which employed (or employer) Boys Home
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.
10-NAME OF FATHER Joseph Lynch
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md
12-MAIDEN NAME OF MOTHER Eleanor Stone
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) John H Lynch
(Address) 2736 St Paul

15- Filed JAN 1 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 31-23

17- I HEREBY CERTIFY, That I attended deceased from ..... 19.19 to Dec 30 19.23
that I last saw h.~~e~~ alive on Dec-30 19.23
and that death occurred, on the date stated above, at 2 15 P.M.
The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Stanhope McCleary M. D
, 19 (Address) 1609 Linden

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet | DATE OF BURIAL, Jan 4 19.24

20-UNDERTAKER Wm Cook | ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82244

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 McGeorge St., 13 WARD)

2-FULL NAME Mary J Krout

(a) RESIDENCE NO. 56 W 28th St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Krout

6 DATE OF BIRTH (month, day, and year) March 28. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

037

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Grover C Krout

(Address) 415 N 24th St

15 Filed DEC 1 1924 Robert E. HARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29-1924

17 I HEREBY CERTIFY, That I attended deceased from 12-28-1923 to 12-29-1924, that I last saw h alive on 12-29-24, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilation Cardiac

(duration) yrs. mos 1 day

CONTRIBUTORY (Secondary) A Myocardia

(duration) yrs. mos. 4 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jno A Dempster Jr M. D.

, 19 (Address) McGeorge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hagerstown

DATE OF BURIAL 1/2 1924

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82245

CERTIFICATE OF DEATH.

90 D 82245

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gel Hospital (St.) ..... (WARD)

2-FULL NAME Martin Welsh

(a) RESIDENCE NO 421 Glen Edwards (ST.) Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Welsh

6 DATE OF BIRTH (month, day, and year): ? ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Abt 57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: 1910 Mt Eutaw

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Michael Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Welsh
(Address) 421 - Glen Edwards Ave

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 21, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. T. Hennessy M. D.
(Coroner)

Jan. 4, 1924 (Address) 280 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross (City)

DATE OF BURIAL: 1-2- 1924

20 UNDERTAKER: Wm Cook

ADDRESS 502 E Mulberry

JAN 1 1924

Robert P. Harrison,
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82246 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 N. North Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora E. Phillips

(a) RESIDENCE. No. 2123 N. North Ave ST., WARD:

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kirby H. Phillips

6 DATE OF BIRTH (month, day, and year) April 16/1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John H. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Coffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lloyd Phillips

(Address) 2123 W. North Ave

15 Filed . 19 Robert P. Harrison, Registrar

JAN 1 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1923, to Dec 29th, 1923, that I last saw her alive on Dec 28, 1923, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

La Grippe

general weakness (duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Heart failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos H. Bullock, M. D.

, 19 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 3 1924

20 UNDERTAKER Chas E. Franck ADDRESS 801 Madison Ave

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82247

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3427 Foster Ave. ST., 76 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelheid Schaefer.

(a) RESIDENCE NO. 3427 Foster Ave ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

(If non-resident give city or town and State)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Schaefer.

6 DATE OF BIRTH (month, day, and year) Oct 15 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Reus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Margaret Reus.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Mary F. Schaefer (Daughter)

(Address) 3427 Foster Ave

15 Filed JAN 7 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3 1923 to Dec. 27 1923, that I last saw h[illegible] alive on [illegible] 19[illegible], and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Indigestion - Anasarca

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Collenberg, M. D.

Jan 5 1924 (Address) 1810 ½ Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Jan 7 1924

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Howard St.

Spec.—1-10-21—M&T—1500 Bks.

D 82248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82248

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 S. Wolfe ST., K WARD)

2-FULL NAME Bernard Paul Birch.

(a) RESIDENCE NO. 309 S. Wolfe ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21st 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER James B. Birch

11 BIRTHPLACE OF FATHER (city or town) Liverpool Eng. (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Stapleton

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant James B. Birch (Address) 309 S. Wolfe St.

15 Filed ....., 19..... Registrar

Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from November 12 1923, to December 30 1923, that I last saw him alive on December 30, 1923, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart Both Mitral & Tricuspid.
for several years.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia due to Rheu

(duration) 8 or 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no the clinical facts of case were ample

What test confirmed diagnosis?

(Signed) J. R. T. Harris, M. D.

, 19 (Address) 1202 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 2 1924
20 UNDERTAKER Lilly & Geier	ADDRESS 400 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82249

CERTIFICATE OF DEATH.

47 D 82249

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Md. Gen'l. Hospital.

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

2-FULL NAME Mrs. Fannie Thomas.

(a) RESIDENCE No. Trinidad Lane, Baltimore, Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Mr John Thomas.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Mitchell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Laden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Mrs. Fannie Thomas. Trinidad Lane, Balt.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JAN 7 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1923, to Dec. 31, 1923, that I last saw her alive on Dec 31, 1923, and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH* was as follows:

Scirrhous Carcinoma of Left Breast with later General Carcinomatosis.

(duration) 1 yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? Yes Date of Dec. 17, 1923

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Tissue Exam.

(Signed) Thos A Dougherty, M. D.

, 19 (Address) Md Gen'l Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 3 1923
20 UNDERTAKER George J. Smith.	ADDRESS 1552 Hollins St

Spec.—1-10-21 M&T 1500 Bks.

D 82250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 82250

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 West 40th. St. ST. 12 WARD)

2-FULL NAME Joseph Edward Shipley

(a) RESIDENCE No. 535 West 40th. St. ST., WARD.....
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Tinley

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond, (State or country) Va.

PARENTS

10 NAME OF FATHER Edward Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Mrs. Anna Shipley
(Address) 535 West 40th. St.

15 Filed ....., 19 Burial Permit Clerk Registrar

JAN 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30. 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1919, to Dec. 30, 1923,

that I last saw h.. alive on Dec. 29, 1923,

and that death occurred, on the date stated above, at 3.21 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, Tuberculous Polyarthritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

Dec. 1923 (Address) 1360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery - Jan. 1, 1924	
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 Calvert, St.

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and undertakers should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2418 Madison Ave. ST.; 7 WARD)

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard W. Cohen

(a) RESIDENCE. No. 2418 Madison Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lena Cohen

6 DATE OF BIRTH (month, day, and year) ? 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Antown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Levis
(Address) 1439 Eastern Ave

15 Filed JAN 1 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1923, to Dec. 30, 1923

that I last saw him alive on Dec. 30, 1923

and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Wm. N. Sippert, M. D.

, 19 (Address) 13 E N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	Jan 1 19 24

20 UNDERTAKER ADDRESS

Jack Levis 1439 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82252

D 82252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Dallas ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mokel

(a) RESIDENCE NO. 319 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Mokel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mt Airy Md

12 MAIDEN NAME OF MOTHER Rebecca Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Mayday Md
(State or country)

14 Informant Thos Mokel
(Address) 319 S. Dallas

15 Filed JAN 1 - 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 19 23, to Dec. 30, 19 23,

that I last saw him alive on Dec. 29, 19 23,

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? difficult breathing

(Signed) M N Patterson, M. D.

12-30, 1923 (Address) 221 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 1 1924
20 UNDERTAKER	ADDRESS
K. L. Good	1405 N. Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 854 W. Oliver St. 21 WARD)

REGISTERED No. 124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Crossley

(a) RESIDENCE No. 854 W. Oliver St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 4 1862

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edna Sander

(Address) 854 W Oliver St

15 Filed JAN 2 - 1924, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/29/ 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/14/ 1923, to 12/29/ 1923,

that I last saw her alive on 12/29/ 1923,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Chew Brolley, M. D.

1/11/ 1924 (Address) 708 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U. S. National Ct — DATE OF BURIAL: Jan 2 1924

20 UNDERTAKER: J. L. Brown & Son — ADDRESS: 708 W Monto

Spec. 1-10-21 MAT 1500 Blks.

D 82254

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 82254

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 Orleans ST., 6 WARD)

2-FULL NAME Howard Isaac Goldstein

(a) RESIDENCE NO. 2009 Orleans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
✓		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jacob Goldstein

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Bertzan

13 BIRTHPLACE OF MOTHER (city or town) Roumania
(State or country)

14 Informant Jacob Goldstein
(Address) 2009 Orleans

15 JAN 2 1924 ROBERT R. KRAUTER Burial Permit Clerk Receiver

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1923, to Jan 1, 1924, that I last saw him alive on Jan 1, 1924, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J Levi M. D.

1. 1924 (Address) 413 W Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel DATE OF BURIAL Jan 2 1924

20 UNDERTAKER Jack Levin ADDRESS 1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Misspelled

D 82255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82255

1-PLACE OF DEATH

City of BALTIMORE: (No. 2011 Ramsey St. 20th Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert E. Mispelhorn

(a) Residence No. 2011 Ramsey St., 20th Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

4-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Mispelhorn

6-DATE OF BIRTH (month, day and year) Jan 25 1864

7-AGE 59 yrs. 11 mos. 4 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hardware

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. - 31

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frederick Mispelhorn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Gelbach

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Emma Mispelhorn

(Address) 2011 Ramsey St.

15-

Filed JAN 2 - 1924 19.. Registrar.....

ROBERT F. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec 30, 23

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1923 to Dec 29 1923

that I last saw him alive on Dec 29 1923

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Tubular Nephritis

..... (Duration) ..... yrs. Unknown mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Wallace A Pratt M. D.

12/31 1923 (Address) 541 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cemetery | DATE OF BURIAL, Jan 2nd 1924

20-UNDERTAKER, F B Hippert | ADDRESS 2256 Fred'k Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

116830 82256

CERTIFICATE OF DEATH.

38 D 82256

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Anthony Richardson

(a) RESIDENCE No. 1032 S. Eutaw ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Stevadore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Spencer

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Cincinnatti

12 MAIDEN NAME OF MOTHER Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923, to Dec 29, 1923, that I last saw him alive on Dec 29, 1923, and that death occurred, on the date stated above, at 9 40 p. m.

The CAUSE OF DEATH* was as follows: Rupture, Aneurism, Abdominal Aorta, Aneurism Femoral artery Right

(duration) 1 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Syphilis, Syphilitic Aortitis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Julian D Hall M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt-Auburn Cemetery — DATE OF BURIAL June 2 1924

20 UNDERTAKER Jere R A Elliott — ADDRESS 1725 Eastland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82257

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520 N. Eden ST. 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Hill

(a) RESIDENCE NO. 520 N. Eden ST., [illegible] WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 1919

7 AGE: Years 4 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Iron

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: David Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Annie Schofield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Annie Hill Mother

(Address): 520 N Eden St

15 Filed JAN 2 - 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1923. to Dec. 30. 1923.

that I last saw him alive on Dec. 29, 1923,

and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

T.B. meningitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Otitis media

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. L. Robinson M. D.

12/31/23 (Address) 1526 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laural Cemetery — DATE OF BURIAL: Jan 2 1924

20 UNDERTAKER: Wm. Robert A. Elliott — ADDRESS: 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001 D 82258

B 82258

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3121 Dillon ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara b. Hartley

(a) RESIDENCE NO. 3121 Dillon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. H. Hartley

6 DATE OF BIRTH (month, day, and year): May 26-1853

7 AGE: Years 70 Months 7 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Michael Flaherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire

12 MAIDEN NAME OF MOTHER: Eliz. Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Irg

14 Informant: Harry Hartley

(Address) 3121 Dillon St.

15 Date received: JAN 2 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Bureau

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Dec 29, 1923, that I last saw her alive on Dec 29, 1923, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

..... (duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Leo. L. Mellus, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. DATE OF BURIAL: Jan 2 1924

20 UNDERTAKER: J. A. Moran ADDRESS 2nd & Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82259

82259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1838 W Franklin St. 70 WARD)

2-FULL NAME Henry Fremont Walters

(a) RESIDENCE. No. 1838 W Franklin St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Walters

6 DATE OF BIRTH (month, day, and year) Sept. 20. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wesselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Walters. (Address) 1838 W. Franklin

15 Filed JAN 2 - 1924 19.... ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th 1923 to Dec 31st 1923

that I last saw he alive on Dec 31st 1923

and that death occurred, on the date stated above, at 4.45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Pernicia Exhaustion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj Ombrellow M. D.

12/31 1923 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 2 1924

20 UNDERTAKER Mrs. Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82260

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 3963 Roland Ave 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dominic A Ledlich

(Residence in Baltimore: No. 3963 Roland Ave St.; 46 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (Write the word.): Married

6-DATE OF BIRTH: Oct 25 (Month) (Day) 1896 (Year)

7-AGE: 27 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Nevitt W Brooks

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Florence Petters

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael J Ledlich

(Address) 3963 Roland Ave

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

JAN 2 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Bratton M. D. (Coroner.)

Jan 1 1924 (Address) 3624 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, Jan 3 1924

20-UNDERTAKER, Ehrenwith & Son — ADDRESS 3617 Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82261 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 82261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 3428 Rolandoc St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Alford E. George

(Residence in Baltimore: No. 3428 Rolandoc St.; yrs. 10 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

6-DATE OF BIRTH: Jan (Month) 1 (Day) 1839 (Year)

7-AGE: 85 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): gen

9-BIRTHPLACE, (State or Country): England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charlotte George

(Address) 3428 Rolandoc

15-

Filed ..... 192.....

Registrar.

JAN 2 - 1924 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec (Month) 31 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner.)

Jan 1 192[illegible] (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL: Balto Cem. DATE OF BURIAL, Jan 3 192[illegible]

20-UNDERTAKER: Chenoweth & Son ADDRESS 3617 Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

32262

CERTIFICATE OF DEATH.

139 D 82262

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 620 W. Mosher St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Elizabeth Jones

(Residence in Baltimore: No. 620 W. Mosher St.; yrs. 15 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	colored	widow

6-DATE OF BIRTH. About (Month) (Day) 1874 (Year)

7-AGE. about 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Haywood

(Address) 613 S. Glenn St.

15-

Filed JAN 2 - 1924 ROBERT A. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 30, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Probably) Heart trouble & uremia

about 1 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Dec 31 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem DATE OF BURIAL, Jan 2 1924

20-UNDERTAKER. Samuel Stanley & Bro. ADDRESS 378

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 258 S.Bouldin St., 76 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence M.Tillett

(a) Residence No. 258 S.Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William M.Tillett

6-DATE OF BIRTH (month, day and year) Feb.19 1853

7-AGE.	If LESS than 1 day,
70 yrs. 10 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Jacobsville Md.

PARENTS.

10-NAME OF FATHER, Wesley L.Linthicum

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Anne Arundel Co. Md.

12-MAIDEN NAME OF MOTHER, Georganna Fishach

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) William M.Tillett

(Address) 258 S.Bouldin St.

15- Filed JAN 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Dec.30 1923

17- I HEREBY CERTIFY, That I attended deceased from June 6, 1921 to Dec 30, 1923

that I last saw her alive on Dec 30, 1923

and that death occurred, on the date stated above, at 8.45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

12/31, 1923 (Signed) Florence B Tillett M. D.

Address 314 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cem. Assn Co	Jan 5, 1924
20-UNDERTAKER.	**ADDRESS**
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

82264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82264

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 N. Fourth St, Brooklyn St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Hannah E. Collison

(a) Residence No. 7 N. Fourth St, Brooklyn St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of J. Wesley Collison

6-DATE OF BIRTH (month, day and year) Oct. 7 1859

7-AGE.	If LESS than 1 day.
64 yrs. 2 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Northumberland Co Va.

PARENTS.

10-NAME OF FATHER. Zion Sebree

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Elizabeth Clark

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Elizabeth Pitts

(Address) 7 N. Fourth St. Brooklyn Md.

15- Filed JAN 2 - 1924 ROBERT A. KRAUTER, Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 31 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1923 to Dec 31 1923

that I last saw h.— alive on Dec 31 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstat Athr (Nony)

(Duration) yrs. mos. 28 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos A Brooke M. D.

, 192) (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	Jan 3.., 1924
20-UNDERTAKER.	ADDRESS
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

B 82265

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 32265

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 W Lanvale ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Sears

(Residence in Baltimore: No. 1406 W Lanvale ave St.; 48 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem	Col	Married

6-DATE OF BIRTH, ... (Month) Dec (Day) 28, (Year) 1875

7-AGE, 48 yrs. 1 mos. 3 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 63

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Armstrong

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rebecca Armstrong

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Wm Sears

(Address)..... 1403 W Lafayette St

15- Filed ..... JAN 2 - 1924 ....., 191.. ROBERT P. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1923, to Dec 31 1923, that I saw h[illegible] alive on Dec 31 1923 and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

..... (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) C. H. Finan M. D.

Jan 1, 1924 (Address) 715 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	....., 1924
20-UNDERTAKER Wm. H. Thuerhemer	ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82266

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 82266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Stirling ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby of Rosie Bush

(a) RESIDENCE NO. 707 Stirling ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs ... mos ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Richard Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosie Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed JAN 2 - 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Dec 28, 1923, that I last saw him alive on Dec 28, 1923, and that death occurred, on the date stated above, at 3.00 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E E Duncan M. D.

12/29, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health.	ADDRESS

JOHNS HOPKINS HOSPITAL JAN 2 1924

Par. Wm. F. ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82267

CERTIFICATE OF DEATH.

24 58-001 D 82267

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 838 Harvey St. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilburn W. Cox.

(a) RESIDENCE. NO. 1457 Andre St. ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12, 1897.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26.	6.	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER William H. Cox.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington Co., Md.

12 MAIDEN NAME OF MOTHER Mary Hine.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington Co., Md.

14 Informant Mary E. Cox.
(Address) 1457 Andre St.

15 Filed JAN 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Dec 31, 1923, that I last saw h[im] alive on Dec 31, 1923 and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

from history (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Morgans, M. D.

Jan 2 1924 (Address) 3400 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery, Jan.	3, 1923. 19
20 UNDERTAKER A. Howard Evans	ADDRESS 1428 S. Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 32268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Richardson

(a) RESIDENCE NO. 411 E. 21½ st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Richardson

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Cosby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Brock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 2 1924, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1923, to Dec. 30, 1923, that I last saw her alive on Dec. 30, 1923, and that death occurred, on the date stated above, at 10.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) L. A. Lally, M. D.

12-31-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn

DATE OF BURIAL 1-3 1924

20 UNDERTAKER David Easton

ADDRESS 916 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82269

CERTIFICATE OF DEATH.

129

D 82269

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Tracton ST. 13 WARD)

2-FULL NAME Andrew Gassaway

(a) RESIDENCE NO. 1402 Tracton ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Rachel Gassaway

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Gassaway

11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Rachel Gassaway (Address) 1402 Tracton St

15 Filed JAN 2 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Dec 30, 1923, that I last saw him alive on Dec 30, 1923 and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Wilbur Frey, M. D.

12/31, 1923 (Address) 1928 a. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Bur

DATE OF BURIAL 1-2- 1924

20 UNDERTAKER Dan'l Kaylor

ADDRESS 916 Lan...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

82270.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-09 82270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 805 S. 3rd St. St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Harris Kornmann

(a) Residence No. 805 S. 3rd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Wh.

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Dec. 30/23.

7-AGE. .....yrs. .....mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Kornmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Margaret R. Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14-
(Informant) Henry Kornmann
(Address) 805 S. 3rd St.

15-
Filed JAN 2 - 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 30 ....., 19 23 to Jan 1 ....., 19 24
that I last saw h.. alive on Jan 1 ....., 19 24
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Premature Birth
(6 mos. utero-gestation)

.....(Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) Henry B. Atkey, M. D.
1/2, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan 2, 1924

20-UNDERTAKER, Zirkeler & Zirkeler — ADDRESS 1739 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82271

O.K. AK Gorsuch Coroner M.D.

CERTIFICATE OF DEATH. X 179

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., W WARD)

2-FULL NAME George Schlimm

(a) RESIDENCE No. Lake Shore Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schlimm

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER John Schlimm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Charles Jones

(Address) 1036 Chase St

15 Filed JAN 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923, to Dec 31, 1923, that I last saw h[illegible] alive on Dec 31, 1923, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) 1st - 2nd - 3rd degree Burns

(duration) ..... yrs. ..... mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) R. I. Pfeiffer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 4 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Lights

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 82272

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2555 Florence ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm J. Waters

(a) RESIDENCE NO. 2555 Florence ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE 35 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: William J Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co md

12 MAIDEN NAME OF MOTHER: Carrie Gilden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co md

14 Informant: Mary Golden

(Address) 2555 Florence st

15 Filed JAN 2 - 1924, 19.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/26 1924 to 1/30 1924, that I last saw h alive on 1/30 1924, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Benj Kletter, M. D.

1/31 1924 (Address) 2178 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Jan 3d 1924

20 UNDERTAKER: Joseph A Farrell — ADDRESS: 2247 Division St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82273

CERTIFICATE OF DEATH.

89 D 82273

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Fopplow ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Leonard.

(a) RESIDENCE NO. 104 S. Fopplow ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Julia Hedrick.

6 DATE OF BIRTH (month, day, and year) Nov. 29. 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	70	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron fr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cecelia Kinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Julia Leonard

(Address) 104 S Fopplow st

15 Filed JAN 2 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31st. 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5th, 1923, to Dec. 31st, 1923,

that I last saw him alive on Dec. 31st, 1923,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Gastroenteritis

Angina Pectoris

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas W. McElfish, M. D.

19 (Address) 145 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 3rd 1924
UNDERTAKER Howard & Son	ADDRESS Catonsville
Per F. Howard	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82274

CERTIFICATE OF DEATH.

D 82274

1-PLACE OF DEATH 735 E Hoffman St

CITY OF BALTIMORE: (No. 735 East Hoffman St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kirby

(a) RESIDENCE NO. 735 East Hoffman St. ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of William O. Kirby

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick, Md.

PARENTS

10 NAME OF FATHER George M. Hartsock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Catherine------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas. H. Houck

(Address) 516 N. Calvert St.

15 Filed ....19.... ROBERT R. KRAUTER, Registrar

JAN 2 - 1924 Chief Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Dec. 30, 1923.

that I last saw her alive on Dec. 30, 1923

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) .... yrs. .... mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Macdonald M. D.

Jan. 1924 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/3/24 19

20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82275

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1406 Bel Av. ST., 74 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Clark

(a) RESIDENCE NO. 1406 Bel Av ST., 74 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced ~~Husband~~ of (or) WIFE of Edgar B. Clark.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Warren Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) 1406 Bel Av

15 Filed JAN 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to Dec 31, 1923, that I last saw h alive on Dec 31, 1923, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Arrest

(duration) yrs. 8 mos 00 ds.

CONTRIBUTORY (Secondary) Cancer of Bowel

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

1/2, 1924 (Address) 1406 Bel Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/2 1924

20 UNDERTAKER [illegible]

ADDRESS 318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSES is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82276

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Laurens ST., 14 WARD)

2-FULL NAME Baby Green

(a) RESIDENCE NO. 525 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 24 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Green

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Briscoe

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) Md

14 Informant Mary Green
(Address) 525 Laurens

15 Filed JAN 2 - 1924, 19 ....

VINCENT M. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1923, to Dec 22 1923, that I last saw h alive on Dec 22nd 1923, and that death occurred, on the date stated above, at 330A m.

The CAUSE OF DEATH* was as follows:

(a) Hemolytic Icter —
7 Months —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Haemolytic Icterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) H. Lee Smith, M. D.

12/28, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hosp

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY AKS

Spec.—1-10-21—M&T—1500 Blks.

D 82277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+57 D 82277

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Grinath

(a) RESIDENCE NO. Fullerton Md. ST., WARD Fullerton Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 11 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Grinath

6 DATE OF BIRTH (month, day, and year) Aug. 10 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Euler

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Haas

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant John J. Grinath (Address) Kearney.

15 Filed JAN 2 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Dec 31, 1923, that I last saw h[illegible] alive on Dec 31, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Diabetes Mellitus [redacted]

(duration) 8 mos 7 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 26, 1923

Was there an autopsy? No

What test confirmed diagnosis? P.S. + Operation

(Signed) Harold C. Gallagher M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. DATE OF BURIAL Jan 3 1924

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pied[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82278

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Druid Hill Av ST., 11 WARD)

2-FULL NAME Maud Jones

(a) RESIDENCE NO. 1311 Druid Hill Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/26/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Robert J. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Francis Baylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Rosa Hall, Sister (Address) 1311 Druid Hill Av.

15 Filed, JAN 2 1924, 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1923, to Dec. 31, 1923, that I last saw her alive on Dec. 31, 1923, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheeling, M. D.

Jan 1 1924 (Address) 1230 Dr. Hun Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Jan 2 1924

20 UNDERTAKER Jas. M. Johnson

ADDRESS 1309 Druid Hill Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82279

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Salgee

(a) RESIDENCE NO. 8 Lewiston Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Mary E. Salgee

6 DATE OF BIRTH (month, day, and year) March 10, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unkn. 07

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Do Balto Md

PARENTS

10 NAME OF FATHER Henry Slagee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do Md

12 MAIDEN NAME OF MOTHER Catherine Magee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do Md

14 Informant (Address) Bay View Hospital

15 Filed JAN 2 1924, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Decemb 21, 1923, to Jan. 1, 1924, that I last saw him alive on Jan. 1, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocardial Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. F. Equitt M. D.

1/4 1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Jan 4, 1924

20 UNDERTAKER Wm. Cook Son & Co. — ADDRESS 1700 Eutaw Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82280 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82280

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Foley

(a) Residence No. Preston & Caroline Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.)

5a-If married, widowed, or ~~divorced~~, ~~HUSBAND~~ of (or) ~~WIFE~~ of Jno. Foley.

6-DATE OF BIRTH (month, day and year) 25 April 1842

7-AGE. 81 yrs. 9 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER, John Hunter.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Maria

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Sister Florence

(Address) Preston & Caroline

15- Filed 19

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h[er] alive on Dec 29 19 23

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D

Jan 2, 1924 (Address) 1183 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood. DATE OF BURIAL. Jan 3 1924

20-UNDERTAKER. Ellwood. ADDRESS 5026 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82281 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 57 D 82281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Pennsylvania ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm J. Egan

(a) RESIDENCE NO. 1204 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah C. Egan

6 DATE OF BIRTH (month, day, and year) Oct 7, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Water Union

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Egan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah Egan (Address) 1111 Penna Ave

15 Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923, to Jan 1, 1924.

that I last saw him alive on Dec 31, 1923

and that death occurred, on the date stated above, at 130P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyme of Foot

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Febling's

(Signed) William E Burpee M. D.

Jan 2 1924 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 3, 1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Mont 24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 82282 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82282

168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 N. Washington ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence D. Kerr

(a) RESIDENCE NO 1031 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fenton Irene Kerr

6 DATE OF BIRTH (month, day, and year) Jan 13/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Packing-house
(b) General nature of industry, business, or establishment in which employed (or employer) not working
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Dick Kerr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie J Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Chas. T. Thompson
(Address) 1708 N. Calvert St.

15 Filed JAN 2 - 1924 Registrar

[Burial Permit Clerk]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation- hung himself from joist in cellar

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Davis, M. D.
(Coroner.)

Jan 1/23 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pimlico Hill Towson	Jan 4 1924
20 UNDERTAKER	ADDRESS
Wm Cook 502 E	Town

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82283 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82283

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 Homestead ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Slaysman

(a) RESIDENCE. NO. 816 Homestead ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single, Married~~ Widowed, or ~~Divorced~~ (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year) Septbr 1st 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Walter Slaysman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Lucy Yingling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Walter Slaysman (Address) 816 Homestead st.

15 Filed JAN 2 - 1924 19 Robert P. Harrison, Registrar

Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1923, to Jan 1st, 1924, that I last saw her alive on ~~Dec~~ Jan 1st, 1924, and that death occurred, on the date stated above at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Jan 3rd 1924

20 UNDERTAKER Leo E. Cook ADDRESS North Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82284 HEALTH DEPARTMENT—CITY OF BALTIMORE, D 82284

CERTIFICATE OF DEATH. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Jones

(a) RESIDENCE NO. 2220 Elmora Ave WARD Walbrook,

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Widowed~~ Sallie E. Jones

6 DATE OF BIRTH (month, day, and year) Sept 2- 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David A. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa. (10)

12 MAIDEN NAME OF MOTHER Katherine Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. (10)

14 Informant Florence W. Jones

(Address) 1103 W. Lafayette St.

15 Filed Jan 2 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923. to Jan. 2, 1924.

that I last saw him alive on Jan 2, 1924,

and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 1/4/24

UNDERTAKER Chas. F. Ernest & Son

ADDRESS 1118 W. Lafayette Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3104 Barclay St., 12 Ward) 74-001

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Stein

(a) Residence No. 3104 Barclay St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe | 4-COLOR OR RACE. Cl | 5-Single, Married, Widowed, or Divorced, (Write the word.) Mar X

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Daniel Stein

6-DATE OF BIRTH (month, day and year) 1861

7-AGE. 62 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Keeping House
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.
10-NAME OF FATHER Samuel Hutton
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Daniel Stein
(Address) 3104 Barclay St.

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.
JAN 2 - 1924 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec, 14 1923 to Dec 31 1923
that I last saw h.. alive on Dec 31 1923
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) J. Randall Shipley M. D.
Jan. 2 1924 (Address) 1534 - 20 St. W.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mt. Auburn Cem.	Jan. 3, 1923
20-UNDERTAKER.	ADDRESS.
Mrs J. G. Locks	352 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

B 82286

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82286

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2313 E Preston St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Feldpusch

(a) Residence No. 2313 E Preston St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo Feldpusch

6-DATE OF BIRTH (month, day and year) Sept 28. 1843

7-AGE. 80 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS:

10-NAME OF FATHER, Geo Knell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Christina Schumacher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs Ann Feldpusch

(Address) 2313 E Preston

15-

Filed JAN 2 - 1924 192.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 31 - 1923

I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923 to Nov 21, 1923

that I last saw h[illegible] alive on Nov 21, 1923

and that death occurred, on the date stated above, at 3.25 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

1

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 1

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. C. Kerr M. D.

Jan 1, 1924 (Address) 201 N Paca St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cemetery	Jan 2, 1924
20-UNDERTAKER. John Allen	ADDRESS. 2008 Eden

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82287 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82287

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 428 E 21st St., 12 Ward)

Registered No.....

2-FULL NAME..... Ellen Boudewark

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 428 E. 21st St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Boudewark

6-DATE OF BIRTH (month, day and year) Oct 6 1883

7-AGE, 40 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Blake

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Mollie Merrick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14-

(Informant) Henry Boudewark Jr

(Address) 428 E. 21st St.

15-

Filed....., 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Jan 1, 1924, that I last saw h.. alive on Dec 31, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart Disease

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(Duration) 8 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Jarvis M. D.

Jan 2, 1924 (Address) 936 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Park Cem

DATE OF BURIAL, Jan 2 1924

20-UNDERTAKER John Ulmer

ADDRESS 2008 Ellamont

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82288

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 905 N. Broadway ~~St.~~, 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William A. Hogg

(a) Residence No. 905 N. Broadway ~~St.~~, 7 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary J. Hogg

6-DATE OF BIRTH (month, day and year) Oct. 23 1848

7-AGE, 75 yrs. 2 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Confectioner

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 019

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas R. Hogg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Mary Groves

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) William H. Hogg

(Address) 905 N. Broadway

15-

Filed JAN 2 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 31/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 23, to Dec 31st 23,

that I last saw h... alive on Dec 31 23,

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY Chronic Nephritis
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Chas R Fisk, M. D.

Jan 2, 19 (Address) 130 W Madison

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer

DATE OF BURIAL, Jan. 3, 1924

20-UNDERTAKER. William G. Schaeffer

ADDRESS 1716 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82289 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82289

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 904 1/2 N. Eutaw St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Carson

(a) Residence No. 904 1/2 N. Eutaw St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Carson

6-DATE OF BIRTH (month, day and year): month not known 1865

7-AGE: 59 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 021
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Henry Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant) Gertrude P. Clarke
(Address) 904 1/2 Eutaw St

15- Filed JAN 2 1924 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jany 1-24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1923 to Jany 1, 1924 that I last saw her alive on Dec. 31, 1923 and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Cystitis incipiens

(Duration) — yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pettelcam M. D.
, 19 (Address) 817 Hamilton Ter.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. | DATE OF BURIAL, 1-3, 1924

20-UNDERTAKER: George A. Gibson | ADDRESS 1736 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 82290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 968 Franklin Rd 16

CITY OF BALTIMORE: (No. [illegible] ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Gibson

(a) RESIDENCE No. 968 Franklin Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo J. Gibson.

6 DATE OF BIRTH (month, day, and year): Aug. 10, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Maurice McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Lawrence Gibson (Address) 968 Franklin Road.

15 Filed Jan 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1923, to Dec 30, 1923, that I last saw h or alive on Dec 30, 1923 and that death occurred, on the date stated above, at 1.19 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No,

What test confirmed diagnosis? Symptoms

(Signed) Chas S Parker M. D.

1-3, 1923 (Address) 5123 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Jan 3 1924

20 UNDERTAKER: Loeb & Cook

ADDRESS: 1003 N. Eutaw St.

JAN 2 - 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 82291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 82291

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1712 S. Chaile St. 23 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguer La Cole

(a) RESIDENCE. No. 1712 S. Charles St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Cole

6 DATE OF BIRTH (month, day, and year) 2.14.94.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Housework 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Dave Heileny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mat Kaon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edward Cole
(Address) 1712 S. Chaile St.

15 Filed JAN 2 - 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.31. 1923.

17 I HEREBY CERTIFY, That I attended deceased from November 15 1923 to December 31 1923, that I last saw h.... alive on December 31 1923, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Laryngeitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas B. Meyer M. D.

, 19 24 (Address) 931 N. Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Jan 3rd 1924
20 UNDERTAKER	ADDRESS
E. Lehlonan & Son	Hanover

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 82292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82292

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Pearl St ST.; WARD)

2-FULL NAME Mary M. Klein

(a) RESIDENCE. No. 7 E. N. Pearl ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Captain Chas F. Klein

6 DATE OF BIRTH (month, day, and year): Feb 14-1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Julius L. Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Maria Spruck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Lanza Kaser
(Address) 8 E. Pearl St

15 Filed ..... Robert P. Harrison, Registrar

JAN 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from June 20 1921, to Dec 31, 1923, that I last saw h.er alive on Dec. 31, 19..., and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) Samuel Ruben M. D.

Jan. 2, 1924 (Address) 1412 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ridge	Jan 3 1924

20 UNDERTAKER: George Schwab ADDRESS: 1101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82293

CERTIFICATE OF DEATH.

90 D 82293

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 N. Charles ST., 23 WARD)

2-FULL NAME Laura E. O'Connell

(a) RESIDENCE NO. 1404 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. P. O'Connell

6 DATE OF BIRTH (month, day, and year) May 21. 1875

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 57

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cinn., (State or country) Ohio

PARENTS

10 NAME OF FATHER William A. Clubb

11 BIRTHPLACE OF FATHER (city or town) Prince Geo's Co., (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) Prince George Co. (State or country) Md.

14 Informant Jas. P. O'Connell
(Address) 1404 N. Charles St.

15 Filed JAN 2 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923, to Dec 31, 1923, that I last saw her alive on Dec 31, 1923, and that death occurred, on the date stated above, at 11.00 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Schwamb, M. D.

Jan 2, 1924 (Address) 119 E. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan. 3 1924
20 UNDERTAKER Margaret E. Flynn	ADDRESS 1422 Light St

WARNING—REGISTERED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82294

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 Linnard St., St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah C. Le Fevre

(Residence in Baltimore: No. Littlestown, Pa., St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: Sept. 19, 1856 (Month) (Day) (Year)

7-AGE: 67 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Adams Co, Pa.

PARENTS.

10-NAME OF FATHER: Levi D. Mans

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Catherine Shriner

13 BIRTHPLACE OF MOTHER, (State or Country): Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. LeFevre

(Address) 715 Linnard St

15- FILED JAN 2 - 1924 Robert P. Harrison, 192.... Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) no history,

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan. 2, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Littlestown Pa.

19-PLACE OF BURIAL OR REMOVAL: Littlestown Pa. DATE OF BURIAL, Jan 3, 1924

20-UNDERTAKER: Geo. H. Little ADDRESS, 2495 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NOTE: state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER. WITH ENDURING INK—THIS IS A PERMANENT RECORD.

D 82295

HEALTH DEPARTMENT—CITY OF BALTIMORE

476

D 82295

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2202 Barclay St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary D. Mills

(Residence in Baltimore: No. 2202 Barclay St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: April 11 (Month) (Day) 1850 (Year)

7-AGE: 73 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Sam. Mills

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Clara Godman

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie L. Wells

(Address) 2202 Barclay St

15. JAN 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D. (Coroner.)

Jan 2 1924 (Address) 1632 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL, Jan 3rd, 1924

20-UNDERTAKER, George Schilling & Sons — ADDRESS 1126 Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

K Bradley

D 82296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 82296

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Park ave ST., 11 WARD)

2-FULL NAME Edward Parkin Keech

(a) RESIDENCE No. 837 Park ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Lillian Anspach Keech

6 DATE OF BIRTH (month, day, and year) 2-23-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dental 055

(b) General nature of industry, business, or establishment in which employed (or employer) Surgeon

(c) ~~Name of employer~~

9 BIRTHPLACE (city or town) (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER Rev. John Reeder Keech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Susan Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Robert R. Carman

(Address) 25 Roland Ave

15 Filed ..... 19.... ROBERT R. KRAUTER, Registrar

JAN 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to January 1, 1924, that I last saw h~~e~~ alive on January 1 1924, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage

(duration) May yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) H Warren Buckler, M. D.

Jan 2, 1924 (Address) 806 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 3 1924
20 UNDERTAKER	ADDRESS
Henry H Jenkins Sons Co	McCulloh Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82297

CERTIFICATE OF DEATH.

D 82297

1-PLACE OF DEATH

REGISTERED NO. 74-001 D 82297

CITY OF BALTIMORE: (No. 1429 Cookie ST.: 24th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Hemling

(a) RESIDENCE. No. 1429 Cookie ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) Nov 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
~~6~~	66	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saw Mill Operator

(b) General nature of industry, business, or establishment in which employed (or employer): Saw mill 086

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Hemling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Bridget Dacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Alfred Hemling
(Address) 1429 Cookie St.

JAN 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923, to Jan 1, 1924, that I last saw h. in alive on Jan. 1, 1924, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Unknown (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) George C. Medairy, M. D.

, 19 (Address) 3304 Gilman Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem A&B	Jan 4 1924

20 UNDERTAKER: A. Howard Evans ADDRESS: 1428 N Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82298

CERTIFICATE OF DEATH.

128

D 82298

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 N. Vincent St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Talbert.

(Residence in Baltimore: No. 221 N. Vincent St. St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, ..., 1850
(Month) (Day) (Year)

7-AGE, 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... 437

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Dont Know.

11-BIRTHPLACE OF FATHER (State or Country) Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Talbert

(Address) 221 N. Vincent St

JAN 3 - 1924 Filed ..... 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 1, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1923, to Jan. 1 1924, that I saw h[illegible] alive on Dec. 29 1923, and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

..... (Duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) James M. Hayes M. D.

1/2, 1924 (Address) 513 N. Arlington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn

DATE OF BURIAL. Jan. 3.., 1924

20-UNDERTAKER Sam'l Hasselbrook

ADDRESS 1402 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD, WRITE PLAINLY, WITH UNFADING INK—

Remarks Alcoholism

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82299

B 82299

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 15 WARD)

2-FULL NAME Otto C Beck

(a) RESIDENCE NO. 3010 Westwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, (~~write~~ the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 31 - 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	—	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elec. Eng

(b) General nature of industry, business, or establishment in which employed (or employer) 024

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Gustav L. Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Albrand

13 BIRTHPLACE OF MOTHER (city or town) Milwaukee (State or country) Wis.

14 Informant Gustave Beck (Address) Same 3010 Westwood Ave.

15 Filed JAN 3 - 1924, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1924, to Jan 1 - 1924, that I last saw h— alive on Jan 1 - 1924, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Chronic myocarditis
Mitral insufficiency
Mitral stenosis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none -

(Signed) M. Alexander Novey, M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Jan 4 1924
20 UNDERTAKER	ADDRESS
Wm J Gickner & Sons	N & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82300

D 82300

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE; (No. 10 ST., WARD)

2-FULL NAME Fred Finney

(a) RESIDENCE NO. 810 Augusta St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Finney

6 DATE OF BIRTH (month, day, and year): April 8-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Basket Maker

(b) General nature of industry, business, or establishment in which employed (or employer): O&C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Fred Finney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Linda Burell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Date: JAN 3 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1923, to Jan 1st, 1924, that I last saw him alive on Jan 1st, 1924, and that death occurred, on the date stated above, at 2 00 a.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

Mitral Stenosis & Insufficiency

Myocarditis Insufficiency

(duration) — yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. Hannon, M. D.

1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dale Cemetery

DATE OF BURIAL: Jany X 1924

UNDERTAKER: Clark & Sinner

ADDRESS: Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82301

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4710 Park Height Ave ST. 27 WARD)

2-FULL NAME Harry Albert Lusby

(a) RESIDENCE NO. 4710 Park Height Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Lila Lusby

6 DATE OF BIRTH (month, day, and year) May 2 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	67	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Lusby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizebeth Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Lila Lusby

(Address) 4710 Park Height Ave

15 Filed JAN 3 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21 1923 to Dec 31 1923.

that I last saw him alive on Dec 31 1923;

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Wallis A Cox, M. D.

1/2 1924 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 3 1924

20 UNDERTAKER Robt J Turner Sons ADDRESS 1402 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82302

CERTIFICATE OF DEATH.

D 82302

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 14 (WARD)

2-FULL NAME Paul Carroll Lincoln

(a) RESIDENCE No. 1523 Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. — mos. — ds. 9 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Evan Carroll

11 BIRTHPLACE OF FATHER (city or town) Fairhaven
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Eleanor Carroll

13 BIRTHPLACE OF MOTHER (city or town) Keene
(State or country) New Hampshire

14 Informant Mother - Eleanor Lincoln
(Address) 1523 Eutaw Place

15 Filed JAN 3 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1923, to Jan 2, 1924, that I last saw him alive on Jan 2, 1924, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Forceps Delivery

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross.	Jan. 2 1924
20 UNDERTAKER	ADDRESS
Woodcock	502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82303

CERTIFICATE OF DEATH.

38 ✓ D 82303

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cicero Fisher

(a) Residence No. 426 S. Caroline St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1882

7-AGE.	If LESS than 1 day,
41 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Robt. Fisher

11-BIRTHPLACE OF FATHER (city or town) (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Adeline Purdon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). North Caroline

14- (Informant) Municipal Hospital Records

(Address) BALTIMORE

15- JAN 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec. 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 14 1923 to December 31 1923, that I last saw him alive on December 31 1923, and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis,
Syphilitic Aortitis
Aortic Insufficiency
(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Hoge M. D

1-2- 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
HOPKINS HOSPITAL.	19....

20-UNDERTAKER,	ADDRESS
Commissioner Health.	JAN 3 - 1924

Per. Wm. E. [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3

Cor.—1-12-23—M&T—100 Blks.

D 82304

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D 82304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Hurbert Alley ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Contee

(a) RESIDENCE No 6[illegible] Hurbert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 29/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robert Contee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Laura Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Laura Jones Contee
(Address): 612 hurbert alley

15 Filed JAN 3 1924 ROBERT A. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31/23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Congental Heart Lesion

(Persistent Foramen Ovale or Ductus Arteriosis) (probable) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Pollitt, M. D.
(Coroner.)

Jan 3 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 5 1924

20 UNDERTAKER: Mac R. A. Elliott — ADDRESS: [illegible] Undertaker

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

See Letter attached 2-6-24 KHG.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82305

D 82305

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 Ensor St. ST., 10 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Remmel

(a) RESIDENCE NO. 637 Ensor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Late Mary Remmel

6 DATE OF BIRTH (month, day, and year) Jan 1 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Mfg

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg.

(c) Name of employer Own

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER C. Remmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Geo. Remmel 637 Ensor St.

15 Filed JAN 3 - 1924 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923, to Dec 30, 1923, that I last saw him alive on Dec 30, 1923, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

Contributory (duration) unknown yrs. mos. ds.

Contributory (Secondary) Varicose ulcer r. infolies right leg. (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) Geo. D. Lear, M. D.

Jan 3, 1924 (Address) 1203 N. Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL Jan. 4 1924

20 UNDERTAKER Geo. F. Roth — ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DR. GEORGE McLEAN
1203 N. CHARLES STREET
BALTIMORE, MD.

Feb. 2 - 1924

Dr. C. Hampson Jones.
Health Commissioner
Baltimore City.

Dear Dr. Jones:-

I am informed by Mr. Luther E. Mackey, 2033
Fulton Ave that there is an error in the death Certificate
of Conrad Remmel and the name of his wife
appearing on the Certificate as Mary Remmel, should be
Anne E. Remmel. You are authorized to make
the change if this may be permissible.

Yours very truly

Geo McLean

Spec.—1-10-21—M&T—1500 Bks.

D 82306

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-009

154 D 82306

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 McHenry ST., 19 WARD)

2-FULL NAME Infant Hart

(a) RESIDENCE NO. 1609 McHenry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31, '23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Thomas Hart

11 BIRTHPLACE OF FATHER (city or town) Barnesville
(State or country) Va

12 MAIDEN NAME OF MOTHER Lula Hill

13 BIRTHPLACE OF MOTHER (city or town) Courtland
(State or country) Va

14 Informant John Thomas Hart
(Address) 1609 McHenry St

15 Filed JAN 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923, to Jan 2, 1924, that I last saw him alive on Jan 2, 1924, and that death occurred, on the date stated above, at 7.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Atelectasis

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hemangioma

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James F. Culbreth, M. D.

1/3, 1924 (Address) 1774 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem — DATE OF BURIAL 1-3 1924

20 UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun Hollins sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82307

100-001 ✓ D 82307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Potugal ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES L. ROBERTS,

(a) RESIDENCE NO. 2018 Potugal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina Roberts,

6 DATE OF BIRTH (month, day, and year) March 20-1878,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice wagon driver,

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Charles Roberts,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, MD.

12 MAIDEN NAME OF MOTHER Elizabeth Rinish,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, MD.

14 Informant Mrs. Lina Roberts, (WIFE)

(Address) 2018 Potugal Street

15 Filed JAN 3 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 1 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923, to Jan 1 1924,

that I last saw h— alive on Jan 1 1924,

and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia —

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral paralysis —

(duration) yrs. mos. [illegible]

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) [illegible] —, M. D.

, 19 (Address) 125 W Mony —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, Bem., DATE OF BURIAL Jan 5" 1924.

20 UNDERTAKER M. J. Sadowski., ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

TYPE • SEE • A

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jeanne

HEALTH DEPARTMENT—CITY OF BALTIMORE

82308 82308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5015 Elmer Ave St.: 27 Ward) 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Marie Jeanne.

(a) RESIDENCE. No. 5015 Elmer Ave St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Jeanne

6 DATE OF BIRTH (month, day, and year) March 19-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	9	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Armend Esser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Leonora Boudipey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George C. Shannon

(Address) 700 Fulton Ave.

JAN 3 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1923, to Jany 2, 1924, that I last saw her alive on Jany 1, 1924, and that death occurred, on the date stated above, at 10.25 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Geo. C. Shannon, M. D.

1/2, 1924 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Jan 4 1924

20 UNDERTAKER ADDRESS

Josiah Dyer 1600 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAKO

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82309 — 161-001 — D 82309

1-PLACE OF DEATH Colonial Hospital

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1124 Mount ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Vlogeanites

(a) RESIDENCE NO. 518 W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 1924

7 AGE — Years — Months — Days ✓ — If LESS than 1 day, 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Colonial Hospital

PARENTS

10 NAME OF FATHER Louis Vlogeanites

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Sophia Vasiliou

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Louis Vlogeanites
(Address) 518 W Saratoga St

15 Filed JAN 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd., 1924, 1-30 PM to 12-30 am. Jan 3. 1924. that I last saw him alive on Jan. 2nd. 5 PM, 1924. and that death occurred, on the date stated above, at 12-30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(Placenta Previa)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Wood, M. D.

, 19 (Address) 11 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Jan 3 1924

20 UNDERTAKER: W M Ponton — ADDRESS: 2230 N Monte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 David Hill Ave ST., 14 WARD)

REGISTERED NO. 82310

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Taylor

(a) RESIDENCE NO. 1904 David Hill Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel C. Taylor

6 DATE OF BIRTH (month, day, and year) 2/3/55

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Rachel C. Taylor 1904 David Hill Ave

15 Filed JAN 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1923, to Dec 31, 1923, that I last saw him alive on Dec 31, 1923, and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 6 yrs. — mos. ..... da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J. Mueller M. D.

1924 (Address) 1220 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	1/31 1924
20 UNDERTAKER John M. Johnson	ADDRESS (1564 Druid Hill

D 32311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 32311

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1011 Penna Ave ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bennie Smolkin

(Residence in Baltimore: No. 1011 Penna St.; 7 yrs., 11 mos. 20 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): single

6-DATE OF BIRTH: Feb. 12, 1920 (Month) (Day) (Year)

7-AGE: 7 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none (child)
(b) General nature of industry, business, or establishment in which employed (or employer): (child)

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Sam Smolkin

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Rose Frankel

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert H. Frankel

(Address) 1225 Cloverdale Rd.

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

JAN - 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 2, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) no treatment

(Duration).....yrs.....mos.....ds.

(Signed) D. Hennessy M. D. (Coroner.)

Jan 3, 1924 (Address) 220 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Int. Carmel

DATE OF BURIAL, Jan. 3, 1924

20-UNDERTAKER Jack Levis

ADDRESS 1439 E. Baltimore

Spec.—1-10-21—M&T—1500 Blks.

D 82312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5/D 82312

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 5 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Schulman

(a) RESIDENCE No. 1208 E. Baltimore St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Saul Schulman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Medzin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records

(Address)

15 Filed ..... 19 .....

Robert P. Harrison,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/3/24 19

17

I HEREBY CERTIFY, That I attended deceased from 12/12/23, 19..., to 1/3/24, 19...

that I last saw h~~e alive~~ on 1/3/24, 19...

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

(a) Cardiac Insufficiency

(b)

(c)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

Cardiac Decompensation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Selby, M. D.

1/3, 1924 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Jan 3 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatic Fever

D 82313

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 1

D 82313

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1425 W. Lombard ST. 19 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Sauminio

(Residence in Baltimore: No. 1425 W. Lombard St.; 79 yrs. 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): single

6-DATE OF BIRTH: March 17, 1844 (Month) (Day) (Year)

7-AGE: 79 yrs. 2 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore City

PARENTS

10-NAME OF FATHER: Conrad S. Sauminio

11-BIRTHPLACE OF FATHER (State or country): Bethlehem, Pa.

12-MAIDEN NAME OF MOTHER: Lydia Walz

13-BIRTHPLACE OF MOTHER (State or country): Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. S. Parkhurst M.D.

(Address) 1410 Park Ave.

15 Robert F. Harrison,

JAN 3 1924 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 1st, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 1923, to January 1924 that I saw h.. alive on January 1st, 1924 and that death occurred, on the date stated above, at 11.10 a m.
The CAUSE OF DEATH* was as follows:

Encephaloid Carcinoma
& Right Breast

(Duration) 2 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. S. Parkhurst M. D.

Jan 1st, 1924 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Jan 5 1924

20-UNDERTAKER: George J. Smith

ADDRESS 1532 Hollins St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 82314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82314

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 131 South Third ave 26 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Sinclair

(a) Residence No. 131 South Third ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 5 days How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah A. Sinclair

6-DATE OF BIRTH (month, day and year) Jan 17, 1840

7-AGE. 83 yrs. 11 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)..... 015

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Sinclair

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jane Gibson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs. William H. Sinclair

(Address) 131 South Third ave

15- Filed JAN 3 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 3 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1923 to January 3 1924

that I last saw him alive on Jan 2 1924

and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) X yrs. X mos. 4 ds.

CONTRIBUTORY (Secondary) Disease Chronic Brights (Duration) One yrs. X mos. X ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same as Brights

(Signed) Jas. F. Swan M. D

(Address) 2005 E 31st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Gillmans Island — DATE OF BURIAL Jan 5, 1924

20-UNDERTAKER Wm. Cook — ADDRESS 502 East North ave

IMPORTANT—PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16816 D 82315

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82315

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Edgar Kendricks

(a) RESIDENCE No. 1912 N. Rose St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Lee Kendrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mattie Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JAN 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1923, to Jan 2, 1924.

that I last saw him alive on Jan 2, 1924.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lung abscess

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Brain abscess

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec 20 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cherryville N. C.	Jan 4 1924
20 UNDERTAKER Joseph Abrens	ADDRESS 221 Bway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tuberculosis
Pulmonary Tuberculosis

Spec.—1-10-21 M&T 1500 Bks.

16 1823 82316

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 82316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Waldo Willard

(a) RESIDENCE NO. 1728 Guilford Ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Known

(b) General nature of industry, business, or establishment in which employed (or employer) ? 081

(c) Name of employer Not Known

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Not Known

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

JAN 3 - 1924 Robert P. HARRISON, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 - 1923 to Jan 2 - 1924.

that I last saw him alive on Jan 2 - 1924.

and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Syphilis

Hemiplegia (Left.

(duration) 2 yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? There was.

What test confirmed diagnosis? Microscopic, Laboratory tests.

(Signed) Charles G. B. Ogden, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Jan 4 1924

20 UNDERTAKER: John O Mitchell — ADDRESS: 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82317

CERTIFICATE OF DEATH.

1294

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Light St. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward E. Yates.

(a) RESIDENCE NO. 1011 Light St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (~~WIFE of~~) Annie M. Yates.

6 DATE OF BIRTH (month, day, and year) April 23, 1868.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick layer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William J. Yates.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Evelyn Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Annie M. Yates. (wife)
(Address) 1011 Light St

Filed JAN 3 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia.

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto H. F. Reinhardt, M. D. (Coroner.)

Jany. 3, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross [illegible]

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82318

11-00 D 82318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 Scott St ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Deimling

(a) RESIDENCE No. 1331 Scott St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. Deimling

6 DATE OF BIRTH (month, day, and year) July 26 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Deimling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Southdown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Deimling

(Address) 1331 Scott St

15 Filed JAN 3 1924 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 19 24

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 23, to Jan 2, 19 24.

that I last saw him alive on , 19 ,

and that death occurred, on the date stated above, at 9 15 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Grip

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifton A Dreen, M. D.

, 19 (Address) 1331 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross M.A.Co

DATE OF BURIAL Jan 4 19 24

20 UNDERTAKER James Dinan & Son

ADDRESS 409 S Paca St

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

D 82319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82319

161-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Carson

(a) RESIDENCE NO. University Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31st 23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. J. Carson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Cunning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Wm J Carson

15 Filed JAN 3 1924, 19 Robert T. Norton Jr. Registrar

Parker Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31st, 1923, to Jan. 2nd, 1924, that I last saw him alive on Jan. 2nd, 1924, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity 7 mos.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Douglass M. D.

1-3, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park for cremation	Jan 4 1924
UNDERTAKER	ADDRESS
Harry H. Witzke	153 W Lombard St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D.82320 HEALTH DEPARTMENT—CITY OF BALTIMORE D.82320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1535 Light St., 24 Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas J Schmidt.

(a) Residence No. 1535 Light St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Married Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lillie Schmidt

6-DATE OF BIRTH (month, day and year) 11-8-1881

7-AGE, 57 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Con Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Bldg

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Lillie Schmidt

(Address) 1535 Light St

15- Filed ..... 19.. Robert F. [illegible], Registrar.

JAN 3 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-3-24

17- I HEREBY CERTIFY, That I attended deceased from March 1st, 1923, to Jany 3, 1924

that I last saw him alive on 1-3, 1924

and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. L. Burlington, M. D.

, 19 (Address) 1026 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, 1-5, 1924

20-UNDERTAKER Wm Cook — ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough. Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Posterior Pulmonary Tuberculosis 3 yrs.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82321

CERTIFICATE OF DEATH.

100-09 D 82321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 S. Chapel St. ST., V WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Deinlein

(a) RESIDENCE NO. 11 S. Chapel St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick mason

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Deinlein

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Eva Schultz

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant Eva Deinlein (Mother)
(Address) 11 S. Chapel St

15 Filed JAN 5 1924, 19 Robert E. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 19 24

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1923, to Jany 1, 1924.
that I last saw h.. alive on ... , 19 ..
and that death occurred, on the date stated above, at 9.15 A.m.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. ... mos 15 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Ehlenberg, M. D.

Jany 3. 1924 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Jan 5 1924

20 UNDERTAKER Lilly & Geiler ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82322

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 So. Highland ave St., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Rupp

(a) RESIDENCE NO. 416 So. Highland ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rupp

6 DATE OF BIRTH (month, day, and year) July 3rd 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER Conrad Rupp

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Elizabeth Rupp

(Address) 416 So. Highland ave

15 Filed JAN 3 - 1924 Robert T. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

(Signed) Thos. R. Harrison, M. D.

Jan 3d, 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Jan 5 1924

20 UNDERTAKER Lilly & Ziehler ADDRESS 403 S. Wolfe St

MAGE should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on b

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Michael)

D 82323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Ht D 82323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. 2nd ST.: 76 WARD)

2-FULL NAME Mary A. Michael

(a) RESIDENCE. NO. 118 S. 2nd ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred several yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Michael

6 DATE OF BIRTH (month, day, and year) March 31 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) housewife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Richard Hoge

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Barbara Griesmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant George H. Michael
(Address) 118 S. 2nd

Filed JAN 3 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 19 24

17 I HEREBY CERTIFY, That I attended deceased from about Jan 1, 19 23, to Jan 1, 19 24,
that I last saw her alive on Jan 1, 19 24,
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

gastric hemorrhage
(Following childbirth Dec 31'23)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) gastric carcinoma

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? (made at home)

(Signed) E. Wenger, M. D.

1 2, 1924 (Address) 1014 S. Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Jan. 4th 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

INK—THIS IS A PERMANENT RECORD. Every item must be filled in, with UNFADING INK, and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82324 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 E. 28th ST., 9 WARD)

2-FULL NAME Ann Colton

(a) RESIDENCE NO. 425 E. 28th. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Colton

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Anthony Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Rachel Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs. Ann Ehrman

(Address) 425 E. 28th. St.

15 Filed JAN 3 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1924

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to Jan 1, 1924.

that I last saw h alive on Jan 1, 1924,

and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Sandman, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	1/4, 19 24
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS could state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS could state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 82325

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 Eastmann ST. 15 WARD)

2-FULL NAME John T Campbell

(a) RESIDENCE No. 552 Eastmann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter (Head)

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Kelly's Hotel

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER William Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mrs Rose Campbell

(Address) 552 Eastmann

15 Filed JAN 3 - 1924 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Jan 1, 1924, that I last saw him alive on Dec 31, 1923, and that death occurred, on the date stated above, at 4 AM m.

The CAUSE OF DEATH* was as follows:

Uremia Consul Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

1/1/24 (Address) 832 W Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 4th 1924

20 UNDERTAKER Parmer & Wright — ADDRESS 1364 Pa Ave

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82326

CERTIFICATE OF DEATH.

75-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Scharnagle

(a) RESIDENCE No. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred over yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Unknown

14 Informant Municipal Hospital Records.

(Address)

15 Filed JAN 3 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2 19 24

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to January 2, 1924, that I last saw him alive on January 1, 1924, and that death occurred, on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Right Hemiplegia

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Fat

(Signed) Claude 9. Howe, M. D.

1-2-1924 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Swantz Cem

DATE OF BURIAL Jan 4 1924

20 UNDERTAKER H H Witzke

ADDRESS Lombard & Gilmore

...GINK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 82327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1328 Mm St St. V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Margreth Karl

(a) Residence No. 1328 Mm St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Karl

6-DATE OF BIRTH (month, day and year) January 6 1868

7-AGE, 54 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Laronze Knorlein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Knorlein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) George Karl

(Address) 1328 Mm St

15-

Filed ..... Robert P. Harrison Registrar.

JAN 3 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 2 19

17- I HEREBY CERTIFY, That I attended deceased from August 1923 to January 2 1924

that I last saw h... alive on January 1 1924

and that death occurred, on the date stated above, at 1915 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of August 23

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) Alfred Strain M. D.

, 19 (Address) 1328 Mm St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	January 8, 1924
20-UNDERTAKER.	ADDRESS
Wendell Dippel	837 Mm

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 82328 D 82328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Lemmon ST.; 18 WARD) REGISTERED No. C 100

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna May Burgess

(Residence in Baltimore: No. 902 Lemmon St.; ...yrs. 1 mos. 9 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. (Month) 25 (Day), 1923 (Year)

7-AGE, ...yrs. 1 mos. 9 da.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, George E. Burgess

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Alia Eckard

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George E. Burgess

(Address) 902 Lemmon St.

15- Robert P. Harrison,

Filed ..., 191... Registrar.

JAN 3 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 31st, 1923, to Jan 3 1924, that I saw her alive on Jan 3 1924, and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(Duration) ...yrs. ...mos. 1 da.

CONTRIBUTORY (Secondary) Intoxication Intestinal

(Duration) ...yrs. ...mos. 6 da.

(Signed) Charles Lavin Godwin M. D.

Jan 3, 1924 (Address) 101 W. Mt. Royal

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, 1/4, 1924

20-UNDERTAKER Geo. F. Smith ADDRESS 1532 Hollins St.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 82329

CERTIFICATE OF DEATH

154-003 V

D 82329

REGISTERED No. C .....

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2719 Harlem Ave ST.: 16 WARD)

2-FULL NAME Howard Lee Dunker

(Residence in Baltimore: No. 2719 Harlem ave St.: ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH October 3, 1923
(Month) (Day) (Year)

7-AGE ..... yrs. 3 mos. ..... ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Baltimore

PARENTS

10-NAME OF FATHER Robert L. Dunker

11-BIRTHPLACE OF FATHER (State or country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary H. Ambrose

13-BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Dunker

(Address) 2719 Harlem Ave

15-

Filed ..... 1924 ..... 191 Robert P. Harrison, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan. 3, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1923, to Jan. 3 1924, that I saw h[illegible] alive on Jan 3, 1924, and that death occurred, on the date stated above, at 3:30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. 1 mos. 8 ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), John Blackwick M. D.

Jan 3, 1924 (Address) 11 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park	Jan 4, 1924

20-UNDERTAKER George J. Smith ADDRESS 1532 Hollins St

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JAN 3

Spec–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82330

CERTIFICATE OF DEATH.

K 101-001 ✓ D 82330

1-PLACE OF DEATH

Registered No. 19

City of BALTIMORE: (No. #1 S. Fulton Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip J. Donnelly

(a) Residence No. #1 S. Fulton Ave St., Ward. Media Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katherine C. Donnelly

6-DATE OF BIRTH (month, day and year) Dec 26 1863.

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Holliston Mass

PARENTS.

10-NAME OF FATHER Matthew Donnelly.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12-MAIDEN NAME OF MOTHER Margaret Keaney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Katherine C. Donnelly

(Address) Media Pa

15- Filed JAN 8 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 1923 to Jan. 3 1924

that I last saw him alive on Jan 3 1924

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe Pneumonia

(Duration) yrs. mos. 3. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? none

(Signed) J. D. Deaver M. D

1924 (Address) 704 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Medial Pa

DATE OF BURIAL, Jan 4 1924

20-UNDERTAKER, John O. Mitchell

ADDRESS 1201 W Fayette St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

82331

CERTIFICATE OF DEATH.

90 D 82331

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Oak St. 17 WARD)

2-FULL NAME Michael F. McLaughlin.

(a) RESIDENCE. No. 1903 Oak St. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854-Feb-17th.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ft Philadelphia, Pa

PARENTS

10 NAME OF FATHER James McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Duffy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. T. J. McLaughlin

(Address) 1621 Ruxton Ave

15 Filed JAN 4 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st - 1924.

17 I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1923 to Jan 1st, 1924, that I last saw him alive on 12 M - Jan 1st, 1924, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

with Right Hemiplegia.

(duration) yrs. mos. 4½ ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) Many yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Symptoms

What test confirmed diagnosis? Clinical

(Signed) Wilmer Brinton, M. D.

, 19 (Address) 1. W. Cor. Calvert & Mt.

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
All Cathedral Cem Phila Pa	1/5 1924
20 UNDERTAKER George J Ruth	ADDRESS 1735 Hanford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82332

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Zdanavitha

(Residence in Baltimore: No. 115 Albemarle St. St.; 18 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Dec. (Month) 15th (Day) 1893 (Year)

7-AGE: 30 yrs. 1 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE, (State or Country): Lithuania

PARENTS.

10-NAME OF FATHER: Michael Zdanavitha

11-BIRTHPLACE OF FATHER, (State or Country): Lithuania

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Zdanavitha

(Address) 115 Albemarle St

15-

Filed, JAN 4 - 1924, 192.

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec Jan 2 - 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Pistol
Shot wound in brain
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. G. Pitts M. D.
(Coroner)
Jan. 4 192 4 (Address) 1039 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Vincents Cemtery — DATE OF BURIAL: 1 4 1923

20-UNDERTAKER: Chas B Kuchaucker — ADDRESS: 637 S Paca St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82333

CERTIFICATE OF DEATH.

113

D 82333

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Binney ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Kirkner

(a) RESIDENCE No. 1619 Binney ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 24/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Kirkner

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Helen Krieger

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Geo. W. Kirkner
(Address) 1619 Binney St

JAN 4 - 1924

Filed ..... 192.. ROBERT R. ... Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Indigestion

(Duration) yrs. mos. ds.

(Signed) Thos. J. Horton, M. D.
(Coroner.)

Jan 3, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Inatitutiona, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 4 1924
20 UNDERTAKER Stephen J Kalkowski	ADDRESS 1100 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82334

CERTIFICATE OF DEATH.

118-002

D 82334

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3019 Clifton Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Kegler Miller

(a) Residence No. 3019 Clifton Ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Theodore Miller

6-DATE OF BIRTH (month, day and year) Nov 17-1839

7-AGE 84 yrs. 1 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ophla Pa

PARENTS:

10-NAME OF FATHER, James B Pennock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Jeanette Keller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

11- (Informant) Frank S Thornton

(Address) 3019 Clifton Ave

13- Filed JAN 4 - 1924 12- ROBERT T. HOLMES Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3rd 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923 to Jan 3rd, 1924.

that I last saw her alive on Jan 3rd, 1924.

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Findings

(Signed) S A Dodds M. D.

Jan 4, 1924 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Pahwaq Memorial Co DE — DATE OF BURIAL, Jan 5th 24

20-UNDERTAKER, V Pertsch & Son — ADDRESS 1123 W Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82335

CERTIFICATE OF DEATH.

74 001 D 82335

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1427 N. Gilmor ST., 9 WARD)

2-FULL NAME Joseph M. Klein

(a) RESIDENCE NO. 1427 N. Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Klein

6 DATE OF BIRTH (month, day, and year): Aug 24. 1846

7 AGE — Years: 77 — Months: 4 — Days: 9 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Matthew Moosman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs George B Hodgson

(Address): 1132 Walbrook Ave

15 Filed ... JAN 4 - 1924 ... 19 ... ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th, 19..., to Jan 3rd, 19 24, that I last saw h... alive on Dec 2nd, 19 24 and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2M ds.

CONTRIBUTORY (Secondary): Coma

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) ... M. D.

Jan 3, 19 24 (Address) 1107 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 7 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82336

CERTIFICATE OF DEATH.

444 82336

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene J Lomas

(a) RESIDENCE NO. 1131 E. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 10. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector dbs

(b) General nature of industry, business, or establishment in which employed (or employer) Metal Inspector

(c) Name of employer Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Pierre Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Elvira Mannen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Alphonse Thomas

(Address) 1131 E North Ave City

15 Filed JAN 4 - 1924 19 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3- 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1923, to Jan 3 1924, that I last saw him alive on Jan 3 1924, and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Cachexia

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver ? ? ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/17/23

Was there an autopsy? no

What test confirmed diagnosis? Operation & Lab. tests

(Signed) H. J. Harper, M. D.

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Jan 5 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82337

CERTIFICATE OF DEATH.

REGISTERED No. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2301 Penna Ave. ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Schwartz

(Residence in Baltimore: No. 2301 Penna Ave. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	married

6-DATE OF BIRTH, April 15, 1879
(Month) (Day) (Year)

7-AGE, 45 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coff. Owner
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dave Schwartz

(Address) 2301 Penna Ave.

JAN 4 - 1924

Filed ....., 191.... ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) No History

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. C. Hemsley M. D.
(Coroner.)

June 3, 1923 (Address) 2502 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	June 4, 1923
20-UNDERTAKER	ADDRESS
Jack Levy	1439 E Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Herman

D 82338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82338

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St & Rutland Ave ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Herman

(a) RESIDENCE NO. 229 No. Broadway ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 43 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Herman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Russia

PARENTS

10 NAME OF FATHER Jones Herman

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael.

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Jack Levis (Address) 1439 E Balto St

15 Filed JAN 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17

I HEREBY CERTIFY, That I attended deceased from 11/27, 1923, to 1/4, 1924, that I last saw him alive on 1/4, 1923, and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Carcinoma of splenic flexure of Colon

(duration) ? yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Diabetes Insipidus

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 11/27/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) ..... M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	Jan 6 1924
20 UNDERTAKER	ADDRESS
Jack Levis	1439 E Balto St

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Bks.

D 82339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82339

Registered No. 128

1-PLACE OF DEATH

City of BALTIMORE: (No. 3319 Edmondson Ave. St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Decker

(a) Residence No. 3319 Edmondson Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Decker

6-DATE OF BIRTH (month, day and year) Jan. 18, 1895

7-AGE. 28 yrs. 11 mos. 15 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William S. Decker

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Amelia Brady

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs. Lula Decker

(Address) 3319 Edmondson Ave.

15- Filed JAN 4 - 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 27, 19 23, to Jan. 2, 19 24

that I last saw him alive on " " 1924,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coalahan, M. D.

1-2, 1924 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cem. Ellicott City	Jan 4, 1924
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 W. Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No history

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82340

CERTIFICATE OF DEATH.

1-PLACE OF DEATH B.& O.R.R.Co. tracks

CITY OF BALTIMORE: (No. Stockholm near Sharp Sts. WARD 18)

2-FULL NAME Martin Miersch.

(a) RESIDENCE NO. 1005 Holton Alley. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? 12 yrs. ---- mos. ---- ds.

(If non-resident give city or town and State)

1886 D 82340

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.,

5a If married, widowed, or divorced, HUSBAND of (~~WIFE of~~) Emma Miersch.

6 DATE OF BIRTH (month, day, and year) October 1, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John H.Miersch.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christine Justi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Anna K. Rahe. (sister)
(Address) 1604 Lemon St.

15 Filed JAN 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mangled about the body by having been run over by Engine #1440 of B.& O.R.R.Co. Accidental death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jan, 3, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Sunset — DATE OF BURIAL 1/4 1924

20 UNDERTAKER Liston T. Tressellbaugh — ADDRESS 2620 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1509 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82341

CERTIFICATE OF DEATH.

X 44 ✓

D 82341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital John ST., 14 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Althea Ann Rogers

(a) RESIDENCE NO. Accomac Co., ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., If of foreign birth? 67 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rogers.

6 DATE OF BIRTH (month, day, and year) Jan. 22-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
67		11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Virginia

PARENTS

10 NAME OF FATHER John Winder

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Sarah Winder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Mrs. Elizabeth Cowan Taylor
(Address) Jackson N. C.

15 Filed JAN 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Jan 4, 1923,

that I last saw her alive on Jan 4, 1923,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Generalized carcinoma of abdominal organs.
(Probably primary in Liver)
(duration) Ill health yrs. 6 mos ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? yes Date of Dec 29, 1923

Was there an autopsy? no.

What test confirmed diagnosis? physical exam

(Signed) R. T. Hoff M. D.

. 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke Va.

DATE OF BURIAL Jan 4 1924

20 UNDERTAKER Willard F. Cropley

ADDRESS 116 Greenleaf Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

82342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 2026 E Baltst St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Stolberg

(a) Residence No. 2026 E Balto Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 5-1875

7-AGE, 48 yrs. 9 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto St

15- JAN 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 4/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 2nd, 1923 to Jan 4th, 1924

that I last saw him alive on Jan 3rd, 1924,

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Aortic + Mitral Regurg, Mitral Stenosis Cardiac Hypertrophy, Hypertension, Nephritis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) A F Ris, M. D.

Jan. 4th, 1923 (Address) 24 E Bway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, Jan 7, 1924

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

82343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 D 82343

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 401 Fulton St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James A LeDoyen

(a) Residence No. 401 Fulton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 2nd 1853

7-AGE. 71 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 040
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER. John F LeDoyen

11-BIRTHPLACE OF FATHER (city or town) (State or Country) France

12-MAIDEN NAME OF MOTHER. Frances Shaw

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14-(Informant) Mary D Conway
(Address) 401 Fulton St

15-Filed JAN 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 2/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Jan 2, 1924, that I last saw him alive on Jan 2, 1924, and that death occurred, on the date stated above, at 11 30A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Hypertension 4 Months
(Duration)
CONTRIBUTORY (Secondary) Pulmonary Edema 1 ds.
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert Nitsch M. D.
1/3/, 1924 (Address) 2157 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Peters Cemetery — DATE OF BURIAL, JAN 5, 1924

20-UNDERTAKER. F B Kippard — ADDRESS 2356 Fred Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82344

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwards Carshman

(a) RESIDENCE NO. Dan Run — ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Police 087
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed JAN 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

JAN 4 1924 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2, 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Kelly, M. D.
(Coroner.)

Jan 4, 1924 (Address) 1639 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 4 1924

20 UNDERTAKER Commissioner Health.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

age as 13 yrs. Date of Death Dec. 31, 1923

None

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 82345

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Chambers

(a) Residence No. 640 Smith St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1897

7-AGE. 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Chambers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Loggins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JAN 4 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 2, '24

17- I HEREBY CERTIFY, That I attended deceased from December 5 19 23 to January 2 19 24

that I last saw her alive on January 2, 19 24

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

General Metastasis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

1-3-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel Registering Mch	Jan 6th, 1924
20-UNDERTAKER,	ADDRESS
Sam'l W. Cole & Son	1400 Madison

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 82346

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 26 WARD)

2-FULL NAME Josephine McCarthy

(a) RESIDENCE No. 3228 Elmley Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	2	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Geo. T. McCarthy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Katherine McCarey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Mr. Geo. T. McCarthy.
(Address) 3228 Elmley Ave.

15 Filed JAN 4 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923 to Jan 4, 1924

that I last saw h[illegible] alive on Jan 4, 1924

and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma Left Kidney

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of 12/28/23

Was there an autopsy? No

What test confirmed diagnosis? Operative Findings

(Signed) J. Norwood Wilson M.D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Philadelphia Pa.

DATE OF BURIAL Jan. 5th 1924

20 UNDERTAKER Henry Hoech Son

ADDRESS 1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82347 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 ✓

CERTIFICATE OF DEATH. D 82347

1-PLACE OF DEATH 1534 W Lexington

CITY OF BALTIMORE: (No. Baltimore and ST., 19 WARD)

2-FULL NAME Willie Brown.

(a) RESIDENCE No. 1534-W. Lexington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Estelle Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Walter Brown (Address) 1534 W Lexington St

15 Filed JAN 4 - 1924 Registrar

ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 3, 1924, that I last saw him alive on Jan 3, 1924, and that death occurred, on the date stated above, at 6 10 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) S. W. Kinney, M. D.

, 19 (Address) 1817 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem DATE OF BURIAL 1-4-1924

UNDERTAKER Daniel J Hanesley ADDRESS W Balto

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82348

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

CERTIFICATE OF DEATH

1-PLACE OF DEATH Church Home and Infirmary — REGISTERED NO. D 82348

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Aspelmeier

(a) RESIDENCE NO. 3806 Foster st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: white — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Aspelmeier

6 DATE OF BIRTH (month, day, and year) Aug 10 1901

7 AGE — Years: 22 — Months: 4 — Days: 22 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Oswald Ramer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Sophie Handschild

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address) John S. Aspelmeier 1102 32nd

15 JAN 4 - 1924 Registrar — ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1923, to Jan. 2, 1924, that I last saw her alive on Jan 2, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pericarditis and pleurisy with effusion

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? clinical methods

(Signed) Sayers Gaunter, M. D.

, 19 (Address) Church Home and Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Jan 6 1924

20 UNDERTAKER: John Miller & Sons — ADDRESS: 2008 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82349

CERTIFICATE OF DEATH.

49 D 82349

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3122 E Lombard St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fritz Knoche.

(a) Residence No. 3122 E Lombard St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	WIDOWED.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Knoche.

6-DATE OF BIRTH (month, day and year) March 28 185[illegible]

7-AGE.	If LESS than 1 day.
69 yrs. 9 mos. 4 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Liquor 045

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Don't Know.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER, Don't. Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Don't Know

14- (Informant) Frank Knoche

(Address) 3122 E Lombard.

15- Filed ..... 192 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 18, 19[illegible], to Jan 2, 19[illegible]

that I last saw h[illegible] alive on [illegible], 19[illegible]

and that death occurred, on the date stated above, at 1[illegible] A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(Right)

Coma

(Duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray Exam.

(Signed) Theodore H. Thomas, M. D.

, 19 (Address) 1013 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oaklawn	Jan 6/24, 19
20-UNDERTAKER. John Ulrich	ADDRESS 2008 Orleans

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82350

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 8 S East Ave. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME OCTAVIA DOUGLASS GRIFFITH.

(a) Residence No. 8 S East Ave. St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (write word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 27 1887

7-AGE. 36 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Augusta Ga.

PARENTS.

10-NAME OF FATHER, Arthur T AlleN/

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Mary M Fell.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ga.

14-

(Informant) Mary D Griffith

(Address) 8 S EastAve.

15-

Filed JAN 4 - 1924 19[illegible] ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-3-24

17- I HEREBY CERTIFY, That I attended deceased from 11-13-23 19.. to 1-3rd 19.24

that I last saw alive on 1-2- 19.24

and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY none
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Hermann M.D.

1-4-1924 (Address) 5419 Balto City

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood

DATE OF BURIAL, Jan 7 19.24

20-UNDERTAKER, John Welsh

ADDRESS. 2008 Orleans st

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82351

CERTIFICATE OF DEATH.

90 D 82351

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2615 West Franklin St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Law Brent

(a) Residence No. 2615 West Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 0 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edsie H Brent

6-DATE OF BIRTH (month, day and year) Dec 12th 1884

7-AGE. 39 yrs. 0 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph L. Brent

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Mary Poulter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Edsie H. Brent

(Address) 2615 West Franklin

15- Filed JAN 4 - 1924 ROBERT A. KRAUSER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 3rd 1924

17- I HEREBY CERTIFY, That I attended deceased from about 6 mos. ago, 19..... to Jan 3, 19 24.

that I last saw h.. alive on Jan 2, 19 24

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

about 1 yrs. mos. days (Duration)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms.

(Signed) C. F. Shemwell M. D.

Jan 4, 1924 (Address) 2226 Madison Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1/5/24
Woodlawn Cemetery	
20-UNDERTAKER, Geo. Weber & Son	ADDRESS 2503 Edmondson Ave

ENTRIES MUST BE MADE IN INK. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No history.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82352

CERTIFICATE OF DEATH.

14 161-001 ✓

D 82352

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 544 Robert St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Baby Berry

(a) Residence No... 544 Robert St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Negro

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 2 1924

7-AGE, ..—.. yrs. ..—.. mos. ..—.. ds. If LESS than 1 day, 12 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James Berry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Langston Va

12-MAIDEN NAME OF MOTHER, Beatrice Hebrew.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Langston, Va.

14- (Informant) Beatrice Berry

(Address) 544 Robert St.

15- Filed ..... 1924 ROBERT P. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 2. 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Jan 2, 1924, that I last saw him alive on Jan 2, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. Mansell Lawrence, M. D.

, 19 (Address) 2051 Division St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL, Jan. 4., 19.23

20-UNDERTAKER Mrs J. G. Locks ADDRESS 1302 Jefferson

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 82353

REGISTERED NO.

(If death occurred in a nospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28th WARD)

2-FULL NAME Mrs Mary Fitzsimmons

(a) RESIDENCE No. Mt Hope Retreat ST., 28th WARD

(Usual place of abode) City Baltimore (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Fitzsimmons

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0 37

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Murphy

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland.

14 Informant Records Dept Mt Hope Retreat (Address) Mt Hope Retreat.

15 Filed ....., 19.... Robert P. Harrison, Registrar

524 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2nd 1924

17

I HEREBY CERTIFY, That I attended deceased from July 28th, 1923, to Jan 2nd, 1924, that I last saw h[illegible] alive on Jan 2nd, 1924, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

abt (duration) 4 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Paranoiac Psychosis

abt (duration) 4 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Jan 3rd, 1924 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Jan 5 1924
20 UNDERTAKER	ADDRESS
F. A. Hance-Son	703 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82354

CERTIFICATE OF DEATH. X 74-001 ✓

D 82354

1-PLACE OF DEATH Christs Institution Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 704 Enson St ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Tucker

(a) RESIDENCE No. 1102 R St N.W Wash. DC ST.

(Usual place of abode)

WARD Wash DC

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col'd	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlott Costy Va

PARENTS

10 NAME OF FATHER Sam Branch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Robert F Elliott

(Address) 1725 Ashland Ave

15 Filed JAN 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from December 5, 1923 to January 1, 1924.

that I last saw her alive on January 1, 1924.

and that death occurred, on the date stated above, at 10. P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Paralysis & Complication Disease (duration) 1 yrs. 2 mos. 5 ds.

18 Where was disease contracted if not at place of death? Wash. D. C.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr S W Kennard, M. D.

1-2, 1924 (Address) 704 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 1/4 Asbury 1924

20 UNDERTAKER Mrs Robert F Elliott

ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-20-21 - E.B.R.S.—400 Blks.

D 82355

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82355

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1416 Mount Royal Ave. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Armstrong McIlvain

(a) Residence No. 1416 Mount Royal Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander McIlvain

6-DATE OF BIRTH (month, day and year) Jan. 23, 1848

7-AGE. 75 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Anderson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Jane Armstrong

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Ireland

11- (Informant) Alexander A. McIlvain

(Address) 1416 Mount Royal Ave.

15- Filed ..... 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 3. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 5 1923 to Jan. 3 1924, that I last saw h[illegible] alive on Jan. 2 1924, and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ... yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis -

(Duration) 12-15 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Austin F. Robinson M. D

1-4 1924 (Address) 1307 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Green Mount Cemetery	1/5 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82356

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-88-03 D 82356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 27 WARD)

2-FULL NAME Elizabeth Leimkuhler

(a) RESIDENCE NO 121 White Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ZXX

6 DATE OF BIRTH (month, day, and year) Oct 4/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work AT home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Leimkuhler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Knapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant G.W.Leimkuhler
(Address) 121 White Ave

15 Filed ....., 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema Lungs-Cardiac Insuffiency

Automobile Accident- Fractured Skull on Dec 25/23 (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Pollitt, (Coroner.) M. D.

Jan 4/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	1/7 192 4
20 UNDERTAKER	ADDRESS
Chas P. Crane & Son	118 W. Mt. Royal Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82357

CERTIFICATE OF DEATH.

89 D 82357

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 757 W. Fayette ST., 4 WARD)

2-FULL NAME Edward Zyller

(a) RESIDENCE NO. 757 W. Fayette ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Examiner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer American Wholesale Corp.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant B. F. Lee (Address) 757 W. Fayette St.

15 Filed ..... 4 ..... 19 ..... Robert P. Garrison, Marital Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1923, to Jan 2, 1924 that I last saw him alive on Jan 1, 1924, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. K. Geesel, M. D.

1-2-, 1924 (Address) 117 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 1/5/1924

20 UNDERTAKER Chas. P. Crane & Son

ADDRESS 1118 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82358

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-003 ✓ D 82358

CERTIFICATE OF DEATH [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Light ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Massimino

(a) RESIDENCE NO. 1703 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Massimino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Carlina Massimino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant
(Address)

15 Filed ....., 19.... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-1, 19 24 to 1-1, 19 24

that I last saw him alive on 1-1, 19 24

and that death occurred, on the date stated above, at 8:20 a m.

The CAUSE OF DEATH* was as follows:

congenital deformity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Parsons, M. D.

1-1, 1924 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. 6216 Rohrer's State Board

DATE OF BURIAL JAN 4 - 1924

20 UNDERTAKER Commissioner Health. Wm. F. WOODALL

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

of Stomach

Spec.—1-10-21—M&T—1500 Blks.

D 82359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 82359

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Division ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Thompson

(a) RESIDENCE NO. 1214 Division ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. \ mos. \ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolphus Thompson

6 DATE OF BIRTH (month, day, and year) 5/30/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Ridenut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Betsey Ridenut

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John H. Johnson, Son (Address) 1214 Division St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1924 to Jan 3, 1924.

that I last saw h..... alive on Jan. 3, 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

1 Bright's Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edw. J. Mueller, M. D.

1924 (Address) 1230 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan 5 1924
20 UNDERTAKER Wm. M. Johnson	ADDRESS 1309 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and old state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82360

175

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Wyeth St., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte J. Eichhorn

(a) RESIDENCE NO. 607 Wyeth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) July 18-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ Ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Frederick C. Eichhorn

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Minnie C. Schultz

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant: Fred. C. Eichhorn (Address) 607 Wyeth St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-3-1924

17

I HEREBY CERTIFY, That I attended deceased from 1-3-, 1924, to 1-3, 1924, that I last saw h~~e~~ alive on 1-3-24, 19....., and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ditto

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Sheppard Krauss, M. D.

, 19 (Address) 1209 Mosher Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London PK Cemetery — DATE OF BURIAL: 1/5 1924

20 UNDERTAKER: Geo Leimbach & Son — ADDRESS: 647 W. Pratt St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

From eating cake

Cor.—1-12-23—M&T—100 Blks.

Dr Porter

D 82361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82361

CERTIFICATE OF DEATH.

7H-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1255 E. North ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Fowler

(a) RESIDENCE NO 1255 E. North ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry E. Fowler

6 DATE OF BIRTH (month, day, and year) April 26-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Harford Co Md

PARENTS

10 NAME OF FATHER David V. Ely

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Benard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co Md

14
Informant Henry E. Fowler
(Address) 1255 E North ave

15
Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3/23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility- arterioscler-

0818 (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Porter, M. D.
(Coroner.)

Jan 4-23, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... d's. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Burying Ground Falls Road	1/6/1924
20 UNDERTAKER	ADDRESS
William Cook	502 E North

TION is very important. See instructions on back of certificate. Exact statement may be properly classified. OCCUPA

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82362

CERTIFICATE OF DEATH.

101-001 ✓ D 82362

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Curtis

(a) RESIDENCE NO. 1019 J. St. Spanows Pt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	18	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Edward Lyles Eggleston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lillie Eggleston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Edward E. Eggleston 1019 J. St Spanows Pt

15 Filed ....., 19 ..... HARRISON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-3-1924

17

I HEREBY CERTIFY, That I attended deceased from 12-30, 1923, to 1-3-, 1924, that I last saw him alive on 1-2-, 1924, and that death occurred, on the date stated above, at 3.10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) about 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Spanows Pt. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

1-3, 1924 (Address) 1702 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mountain View Cem. Dundalk	Jan 4 1924
20 UNDERTAKER	ADDRESS
Sam W. Chase Co	1400 Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82363

CERTIFICATE OF DEATH.

101-001 ✓ D 82363

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Gorsuch Ave St. 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Teresa Townsend

(a) RESIDENCE NO. 1112 Gorsuch Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a ~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ William Townsend

6 DATE OF BIRTH (month, day, and year) Jan 6 - 1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ...min.
72	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Locke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cathrine Franck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Sophia Townsend

(Address) 1112 Gorsuch ave

15 Filed ....., 19.....

Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 — 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923 to Jan 3 - 1924, that I last saw living on Jan 3 - 1924, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

1/3, 1924 (Address) 1857 Penna. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Jan 5 1924

20 UNDERTAKER Martin Feaheny & Son

ADDRESS 1529 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 E. Randall ST., 24 WARD)

REGISTERED NO. 29 D 82364

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Cochran

(a) RESIDENCE NO. 135 E. Randall ST., WARD

(Usual place of abode) (If non-resident give city or town und State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 3. 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER John Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Albert Cochran (Address) 135 E. Randall

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to Jan 4, 1924.

that I last saw her alive on Jan 3, 1924,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sat

(Signed) Mile Stifler M. D.

1/4, 1924 (Address) 1319 Leghorn St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Jan 7 1924
20 UNDERTAKER	ADDRESS
Margaret D. Flynn	1422 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Rks.

D 82365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82365

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brown

(a) RESIDENCE NO. 234 N. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State) S. Carolina

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	0	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina
(State or country)

PARENTS

10 NAME OF FATHER Jim. Brown

11 BIRTHPLACE OF FATHER (city or town) S. C.,
(State or country)

12 MAIDEN NAME OF MOTHER Ella Brown

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant University Hospital Record.
(Address)

15 Filed JAN 5 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1923, to Dec. 30, 1923, that I last saw him alive on Dec. 30, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia,
with Pleurisy & Empyema
Uncertain possibly 2 mos.
Chr. Laryngitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure,
Uncertain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) John M. Edmunds M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 5 1924
20 UNDERTAKER	ADDRESS
P. Gross	1406 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82366

CERTIFICATE OF DEATH.

90 D 82366

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 28 Bruce St. (ST.) 19 (WARD)

2-FULL NAME Dorothy Young.

(a) RESIDENCE. No. 28 Bruce St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Young

6 DATE OF BIRTH (month, day, and year): Feb 14 -

7 AGE: Years 39 Months 10 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: John Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dead

12 MAIDEN NAME OF MOTHER: Louisa Ann Hutchins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John Young (Address) 28 W. Bruce St

15 Filed ..... 19 ..... Registrar

Robert F. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 27th 1923, to Jan 22 1924, that I last saw her alive on Jan 1 1924, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) Geo. D. Lattenbach, M. D.

and (Address) 2215 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1/25 1924
20 UNDERTAKER Samuel J Handley	ADDRESS 478 W Balto

JAN 25 1924

IMPORTANT—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82367

CERTIFICATE OF DEATH.

129 D 82367

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1546 Argyle Ave ST., 14 WARD)

2-FULL NAME Mary A Johnson

(a) RESIDENCE NO. 1546 Argyle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Johnson

6 DATE OF BIRTH (month, day, and year): Galestown, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Samuel Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Sarah Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chas Co Md

14 Informant: Mrs Sarah Marriott

(Address) 1546 Argyle Ave

15 Filed ..... 19 ..... Robert F. Harrigan, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923, to Jan. 2, 1924, that I last saw h[illegible] alive on Dec. 31, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary): Mitral regurgitation

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo E Robinson M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Co | DATE OF BURIAL: 1/5 1924

20 UNDERTAKER: Samuel Hendley | ADDRESS: 1918

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

JAN 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82368

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Maitland

(a) Residence No. 317 Otterbein St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1892

7-AGE. 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Maitland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). North Carolina

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JAN 5 - 1924 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from October 31 19 23 to January 1 19 24

that I last saw him alive on January 1 19 24

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension

Chronic Nephritis

(Duration) yrs. 8 mos. (history) ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude A. Drach, M. D

1-2-. 19 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL. 1/6 19 24

20-UNDERTAKER Edward Handy ADDRESS 1 [illegible]

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

DO NOT FOLD

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82369

CERTIFICATE OF DEATH.

9 94-04 82369

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1660 Gorsuch Ave ST., 9 WARD)

2-FULL NAME Jacob W. Smith

(a) RESIDENCE NO Allen, Nebraska ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6 DATE OF BIRTH (month, day, and year) August 15/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Penna.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Esyello

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) New Jersey

14 Informant James M. Smith (Bro)
(Address) Allen Nebraska

15 Filed N5 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Apoplexy - probably Hemorrhage

5 hrs (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) undetermined (duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. S. Fuller, M. D.
(Coroner.)

Jan 3/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Allen Nebraska

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allen, Nebraska. DATE OF BURIAL Jan 5 1924

20 UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82370

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541 W. Hoffman ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elegas Smith

(a) RESIDENCE NO. 541 W Hoffman ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1868

7 AGE: Years 55; Months ...; Days ...; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Estelle Tontz

(Address) 541 W Hoffman

15 Filed JAN 5 1924, 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1923, to Jan 1, 1924, that I last saw h... alive on Dec 31, 1923, and that death occurred, on the date stated above, at 12:20 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) J Norwood, M. D.

Jan 5, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan. 6 1923

20 UNDERTAKER: Joseph A. Farrell — ADDRESS: 234 Monroe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82371

D 82371

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillsdale, Maryland ST., 28 WARD)

2-FULL NAME John J. Whitmore

(a) RESIDENCE NO. Hillsdale, Maryland ST., WARD .....
(Usual place of abode) Forrest Ave.
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Whitmore

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick County Maryland

PARENTS

10 NAME OF FATHER Benjamin Whitmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll County Maryland

12 MAIDEN NAME OF MOTHER Mort

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll County Maryland

14 Informant Clarence E. Whitmore
(Address) Hillsdale, Maryland

15 Filed JAN 5 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923, to Jan 4, 1924
that I last saw him alive on Jan 3, 1924
and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
from history of cases
1 year
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Mass in abdomen

(Signed) A. C. Gunnels, M. D.
Jan 4, 1924 (Address) 4509 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Md
Rocky Ridge Cemetery

DATE OF BURIAL Jan 7 1924

20 UNDERTAKER Jas B Cook

ADDRESS 1003 W Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Dukeland ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace H Kruzmund

(a) RESIDENCE NO. 1818 Dukeland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 1st 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edgar H Kruzmund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lillian L Smartt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edgar H Kruzmund

(Address) 1818 Dukeland ave

15 Filed JAN 5 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1923 to Jan. 3, 1924

that I last saw him alive on Jan 3, 1924

and that death occurred, on the date stated above, at 8.22 a m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. R. C. Kellam M. D.

1/3/24 (Address) 2757 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 7 1924
20 UNDERTAKER	ADDRESS
Geo Schilling & Sons	1126 Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1122 W. Mount ST., 7 WARD)

REGISTERED NO. 128

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie Jager

(a) RESIDENCE NO. 2306 East Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Custer Jager

6 DATE OF BIRTH (month, day, and year) Oct 8 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia (State or country)

PARENTS

10 NAME OF FATHER Joseph Novela

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Custer Jager (Address) 2306 E. Madison

15 Filed JAN 5 1924, 19 Robert F. Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 1924.

17 I HEREBY CERTIFY, That I attended deceased from December 27, 1923, to January 4, 1924, that I last saw h.r alive on January 4, 1924 and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Bright's disease

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Edward Novak, M. D.

, 19 (Address) 266 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL Jan 6 1924

20 UNDERTAKER Grant Goodson — ADDRESS 1906 Eastern Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal Condition

Spec.—1-10-21—M&T—1500 Bks.

D 82374

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 82374

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Saratoga ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Robinson

(a) RESIDENCE NO. 1816 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent S.

6 DATE OF BIRTH (month, day, and year) Aug. 14-1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles G Delany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Jane Donnely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lillian D Robinson

(Address) 1816 W. Saratoga St.

15 Filed JAN 5 1924, 19 Robert F. Leech, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1923, to Jan 3rd, 1924, that I last saw h[illegible] alive on Jan 3rd, 1924, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. H. Rhoads, M. D.

, 19 (Address) 2409 Mad. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: Jan 7 1924

20 UNDERTAKER: F.A. Krauss + Son

ADDRESS: 732 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82375

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 82375

CERTIFICATE OF DEATH.

6

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henderson

(a) Residence No. 204 N. Spring St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1881

7-AGE: 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER: Hooper Henderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

11- (Informant) Municipal Hospital Records

(Address)

15- Filed Robert P. Harrison, Registrar.

NOV 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 4, 1923 to January 2, 1924, that I last saw him alive on January 2, 1924, and that death occurred, on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pneumococcus, Septicemia

Pneumococcus Meningitis

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sub + Autopsy

(Signed) Claude G. Kranz, M. D

1-3-, 1924 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Jan. 6, 1924
20-UNDERTAKER, John W. Henderson	ADDRESS 1603 E Monument St

In filling out this certificate, abbreviations should be avoided. All statements should be clearly and legibly written. All questions should be answered. If physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82376

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 82376

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Sterling ST. 10 WARD)

2-FULL NAME Ellen C. Doyle

(a) RESIDENCE NO 926 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Patrick C. Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine C. Marden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph E. Doyle
(Address) 926 Sterling St

15 Filed ..... 192 ..... Registrar

JAN 5 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy- Probably Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J S H Doyle, M. D. (Coroner.)

Jan 5/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Pan — DATE OF BURIAL 1 192 3

20 UNDERTAKER H. C. Niedfeld — ADDRESS 914 Greenmount Ave

TION is very important. See instructions on back of certificate.

Spec—12-20-21—E.B.R.S.—400 Blks.

(Urbanski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82377

D 82377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladyslaw Urbanski

(a) Residence No. 2635 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 22/1922

7-AGE. 1 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ooo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Edward Urbanski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, ? Kopyarenska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Hospital Record

(Address)

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 4-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 4, 1924, that I last saw h. alive on Jan 4, 1924, and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain from blow on head sustained the previous day

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross appearance

(Signed) Jerome Cobb M. D.

, 19 (Address) 3 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Rosary	Jan 5, 1924
20-UNDERTAKER	ADDRESS
F W Ozarowski	2130 Eastern

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Indefinite terms such as laborer, clerk, manufacturer, merchant, etc., should be avoided. CAUSE OF DEATH must be properly classified. Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms): *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Accidental ~~suicide~~
Fall into a garden
of Christmas Tree.

Spec.—1-10-21—M&T—1500 Bks.

D 82378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82378

CERTIFICATE OF DEATH.

× 118-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Union Ave ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Wossowski

(a) RESIDENCE NO. 1001 Union Ave ST., ... WARD Clarksville Md

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Wossowski

6 DATE OF BIRTH (month, day, and year): Nov 11, 1840

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Charlotte Lawrence

(Address) 1527 N. Wolfe St.

15 Filed JAN 5 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1923. to Jan 3, 1924.

that I last saw her alive on Jan 3, 1924,

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Contusion

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Strangulated Hernia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A. Lof, M. D.

1.4. 1924 (Address) 3471 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Pauls Lutheran Cem. Howard Co

DATE OF BURIAL: Jan. 6 1924

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82379

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. P.W.B.R.R. Track South Ford Rd ST., 1881-60 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Durham

(a) RESIDENCE NO. 1925 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Durham

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1889

7 AGE	34 Years	2 Months	16 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 073
(b) General nature of industry, business, or establishment in which employed (or employer) Frank Walker
(c) Name of employer P.R.R. Co

9 BIRTHPLACE (city or town) (State or country) Dover Delaware

PARENTS

10 NAME OF FATHER Robert Durham

11 BIRTHPLACE OF FATHER (city or town) Dover (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Simmons

13 BIRTHPLACE OF MOTHER (city or town) Dover (State or country) Delaware

14 Informant Myrtle Durham
(Address) 1925 Druid Hill Ave

15 Filed ....., 192 Robert P. Harrison, Registrar

Jan -1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 - 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

R.R. Accident
Multiple Fractures
Shock (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo Clinton Black, M. D.
(Coroner)

Jan 3 192 (Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dover Delaware	Jan 6 192 4

20 UNDERTAKER George T. G. Linton ADDRESS 1735 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82380

CERTIFICATE OF DEATH.

100-001 D 82380

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. University Hospital ST., 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dwyer

(a) RESIDENCE No. 4 Main St. Mt. Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov. 1 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Howard A. Dwyer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Gilmore

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Hospital Records (Address)

15 JAN 5 - 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1923, to Jan 4, 1924, that I last saw her alive on Jan 4, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cleft palate and Hair lip

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov. 8. 23

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Blair Allen, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/5 1924

20 UNDERTAKER J. Slater Sons

ADDRESS 1318 Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82381

CERTIFICATE OF DEATH.

18-005 D 82381

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 So. East Ave ST., WARD)

2-FULL NAME Harry A. Stinchcomb

(a) RESIDENCE NO. 437 So. Robinson St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14/899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odo
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Nelson A. Stinchcomb

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER May C. Stone

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Nelson A. Stinchcomb
(Address) Penfield, A.A.Co. Md

15 Filed JAN 5 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Gas Poisoning

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) working in a closed Garage

(duration) ..... yrs. 2 mos. ..... ds.

(Signed) Jos. B. Ashton, M. D.
(Coroner.)

Jan 4 192 4 (Address) Curtis Bay

*Diseases Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) (1) Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Home Cemetery Penfield A.A.Co. Md Via Balto	Jan 6 1924

20 UNDERTAKER John H. Denny ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T 1500 Blks.

1689 D 82382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 82382

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 27 WARD)

2-FULL NAME Mary Eclark

(a) RESIDENCE NO. Evergreen Apts Palmer ~~WARD~~ Spalding Ave
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Black

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Lovelace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 5 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923, to Jan 4, 1924

that I last saw her alive on Jan 4, 1924

and that death occurred, on the date stated above, at 12 12 P. M.

The CAUSE OF DEATH* was as follows:

Retro-peritneal Sarcoma

(duration) 0 yrs. 5 mos 0 ds.

CONTRIBUTORY (Secondary) None —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Tawana A Cohn, M. D.

1/4, 1924 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Jan 7 1924

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82383

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital #1 ST., 17 WARD)

2-FULL NAME George Ferrier.

(a) RESIDENCE No. U.S. Marine Hospital #1 ST., ... WARD .....
(Usual place of abode) Baltimore, Md.
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Ferrier.

6 DATE OF BIRTH (month, day, and year) Jan. 27 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	11	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman. 086
(b) General nature of industry, business, or establishment in which employed (or employer) Quartermaster
(c) Name of employer S/S Pres. Polk.

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Ida Weeks
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Self.
(Address) .....

15 Filed ..... 1924 ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 29 1923, to January 4 1924, that I last saw him alive on January 4 1924, and that death occurred on the date stated above, at 4 07 a. m.

The CAUSE OF DEATH*, was as follows:
Tuberculosis, Pulmonary Chronic

(duration) 1 yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? —

(Signed) H. L. Foster, M. D.
, 19 (Address) U.S. Marine Hospital. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Jan 7 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

82384 ~~D 82384~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. * 57 D 82384

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard & Greene ST. ~~Private Room~~ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Halidayoke.

(a) RESIDENCE NO. Annapolis Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Lukewarm

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis

PARENTS

10 NAME OF FATHER Daniel F Halidayoke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret F Strange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant University Hospital (Address) Lombard & Greene Sts.

15 Filed Jan 5, 1924 ROBERT R. KNAUFF Registrar

JAN 6 - 1924 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 5 1924, that I last saw him alive on Jan 5, 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bellulitis of Appendix.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known.

Did an operation precede death? Yes Date of Jan 5-1924

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Blood Exam

(Signed) W Wallace Walker, M. D.

, 19 (Address) University Hospital Lombard & Greene Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md. DATE OF BURIAL June 5 1924

20 UNDERTAKER Jas L. Taylor & Son ADDRESS Annapolis Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82385

CERTIFICATE OF DEATH.

3 D 82385

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 16 WARD)

2-FULL NAME Eliza Carter

(a) RESIDENCE No. 1039 Stricker st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eva Gaskins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 6 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1923, to Jan. 4, 1924,

that I last saw her alive on Jan. 4, 1924,

and that death occurred, on the date stated above, at 8.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) [illegible], M. D.

1-4-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Hy. Va	1/6 1924
20 UNDERTAKER	ADDRESS
J H Scudder	141 W Hill

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82386 — 10/09 — 82386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ~~No.~~ ..... ST., 72 WARD)

2-FULL NAME Thomas Brown

(a) RESIDENCE No. 530 N Lee St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Brown

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Camden Station

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Jennie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JAN 6 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 —, 1924, to Jan 4, 1924, that I last saw h... alive on Jan 4, 1924, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X Ray; Blood Culture

(Signed) T. R. Hannon, M. D.

1/4, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 1/8 1924

20 UNDERTAKER J. H. Jordan

ADDRESS 14 N Howard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82387

CERTIFICATE OF DEATH.

8 D 82387

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 309 N. Exeter ST. 5 WARD)

2-FULL NAME Mattie Griffin

(a) RESIDENCE NO. 309 N. Exeter ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 15 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan Griffin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 25 – Months – Days – If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer): Washington

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Hattie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Nathan Griffin 309 N Exeter St

15 Filed JAN 6 1924 19..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1924, to Jan. 4, 1924,

that I last saw her alive on Jan. 4, 1924,

and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Scarlatina

(duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jacob Robinson M.D.

1/5 1924 (Address) 1525 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cemetery — DATE OF BURIAL: Jan 6 1924

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82388

CERTIFICATE OF DEATH

D 82388

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2328 Madison ave (ST. 13 WARD)

2-FULL NAME Beulah Chideckel (90)

(Residence in Baltimore: No. 2328 Madison ave St. 12 yrs. ..... mos. ..... ds.)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: April 10 (Month), (Day), 1857 (Year)

7-AGE: 66 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Mordecai ~~Swerdlow~~ Chideckel

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Swerdlow

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maurice Chideckel

(Address) 2328 Madison ave

15. Filed JAN 6 - 1924, 19.. ROBERT R. KRAUTER, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan 4th (Month) (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1923 to Jan 4 1924

that I saw her alive on Jan 4 1924

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Myocardial Insufficiency

(Duration) ..... yrs. 3 mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Herman Seidel M. D.

Jan 5, 1924 (Address) 2404 Eutaw PC

*State the DISEASE CAUSING DEATH, or, if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. 1 mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Fehrenbach

DATE OF BURIAL: Jan 6, 1924

20-UNDERTAKER: Jack Levin

ADDRESS: 1439 E. Bals

Please write plainly. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT, CITY OF BALTIMORE

Spec.—1-10-21—M&T—1509 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82389

CERTIFICATE OF DEATH.

57

D 82389

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

2-FULL NAME Bessie Kaplan

(a) RESIDENCE NO. 338 Forest St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Kaplan

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac L. Rudavsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 Filed ..... 19 .....

JAN 6 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 4, 1924, that I last saw her alive on Jan 4, 1924, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isaac L. Wilner M. D.

1/4. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery DATE OF BURIAL: Jan 6 1924

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82390

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3503 Fraser Park Av., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara E. Englar

(Residence in Baltimore: No. 3503 Fraser Park Ave St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

6-DATE OF BIRTH. Aug. 4 (Month) (Day) 1864 (Year)

7-AGE. 59 yrs. 5 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Ebenezer Englar

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Margaret Buckey

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clayton H. Englar

(Address) 3503 Fraser Park Av

15- JAN 6 - 1924 ROBERT R. KRAUTER

Filed ..... 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 5 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

suicide by gas
(Housemaking)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) 0

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 5, 1924 (Address) 2802 Edmondson Av

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental**, **Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Canada 60

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Pipe Creek Cem. Co.	Jan 7/24, 1924

20-UNDERTAKER, John G. Mitchell ADDRESS 1201 W. Fayette st

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 llks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82391

CERTIFICATE OF DEATH.

101-001 ✓ D 82391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 W. Madison ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin Kennady Robinson

(a) RESIDENCE No. 205 W. Madison St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Katherin Cyphreth

6 DATE OF BIRTH (month, day, and year) June 13 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postmaster

(b) General nature of industry, business, or establishment in which employed (or employer) (retired) Ob

(c) Name of employer U.S.A

9 BIRTHPLACE (city or town) (State or country) Wilmington Del

PARENTS

10 NAME OF FATHER John T. Robinson

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Delaware,

12 MAIDEN NAME OF MOTHER Martha Cary

13 BIRTHPLACE OF MOTHER (city or town) Wilmington (State or country) Del

14 Informant Miss R. G. Robinson (daughter)

(Address) 205 W. Madison St

15 Filed JAN 7 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to Jan 4, 1924.

that I last saw him alive on January 4th, 1924

and that death occurred, on the date stated above, at 1 30 a, m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis, arteriosclerosis

(duration) 3 yrs.+ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chill fever, dyspnoea, delirium Rapid pulse consolidation

(Signed) Chas Chrystal, M. D.

, 19 (Address) 1701 Madison Ave, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del.

DATE OF BURIAL Jan 7th 1924

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 82392

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Halbrook Ave ST. 15 WARD)

2-FULL NAME Mary Catharine Hughes.

(a) RESIDENCE NO. 3101 Halbrook Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 28" 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fayetteville Pa

PARENTS

10 NAME OF FATHER Michael F. Hughes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McCauchy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant James Byrnes. (Address) 3101 Halbrook Ave.

15 Filed JAN 5 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Jan 4, 1924, that I last saw her alive on Jan 4, 1924, and that death occurred, on the date stated above, at 45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sym. Syncopal

(Signed) Walter Clay, M. D.

1/5, 1924 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Jany 7" 1924

20 UNDERTAKER Wm J Hartnett — ADDRESS 2236 W. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1560 Bks.

D 82393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 ✓ 82393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 70 WARD)

2-FULL NAME Mrs Edna Arnold

(a) RESIDENCE No. Primrose Ave City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Arnold

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Henry Arnold

(Address) Sandy Park Cemetery

15 JAN 6 - 1924 ROBERT R. KRAUTER, Registrar

Filed ..... 19 .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Jan 4, 1924, that I last saw her alive on Jan 4, 1924, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis Cardiac Hypertrophy, Chr Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/31/23

Was there an autopsy? Surgical Service

What test confirmed diagnosis? Phys. Diag

(Signed) H V Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Jan 7 1924

20 UNDERTAKER E. W. Dill

ADDRESS 3109 Frederick Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Crawford

D 82394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 82394

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1240 W Pratt ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M Crawford

(a) RESIDENCE. No. 1240 W Pratt ST., 18 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Crawford

6 DATE OF BIRTH (month, day, and year) Mar 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co

12 MAIDEN NAME OF MOTHER Elizabeth Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ann Arundel

14 Informant Lista Brady

(Address) 1240 W. Pratt

15 Filed JAN 6 1924, 19.... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/24 19

17

I HEREBY CERTIFY, That I attended deceased from 12/26/23, 19..., to 1/5/24, 19..., that I last saw her alive on 1/4/24, 19..., and that death occurred, on the date stated above, at 3—6 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chr Ad Nephritis

(duration) 6 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) T. H. Vansant, M. D.

1/6/24 (Address) 302 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 7 19
20 UNDERTAKER	ADDRESS
John J Field	1200 W Lombard

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82395

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 82395

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hosp.

CITY OF BALTIMORE: (No. Balto., Md. ST., 21 WARD)

2-FULL NAME Margaret Emrich

(a) RESIDENCE No. 785 St. Peter ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) May 1 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER M. W Garythorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant John Scholler (Schollian)
(Address) 790 St Peters

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 30th, 1923, to Jan 4, 1924, that I last saw her alive on Jan 4, 1924, and that death occurred, on the date stated above, at 8.15 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

8 (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) S. Goldman, M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Jan 8 1924

20 UNDERTAKER John Feldt — ADDRESS 1200 N Fremont

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82396 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90 D 82396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 510 N. Schroeder St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Greisz

(Residence in Baltimore: No. 510 N. Schroeder St. St.; 14 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH, July 20 (Month) (Day) 1909 (Year)

7-AGE.	If LESS than 1 day,
14 yrs. 5 mos. 16 ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Julius M. Greisz

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna M. Krdck

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius M. Greisz

(Address) 510 N. Schroeder St.

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 5 1924 (Address) 2802 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Loudon Park	Jan. 7th 1924

20-UNDERTAKER,	ADDRESS
William Cook	505 E North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82397

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82397

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME Emma Stitcher (Emma Stitcher)

(a) RESIDENCE No. Bay View Asylum ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Peter Stitcher.

6 DATE OF BIRTH (month, day, and year) 1851 April 4.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Christopher C. Hughes

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed JAN 6 1924 ROBERT A. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3, 1924

17

I HEREBY CERTIFY, That I attended deceased from November 1, 1917, to January 3, 1924, that I last saw her alive on January 3, 1924, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sol

(Signed) Claude G. Wilmer M. D.

1-4, 1924 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/7 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Vo

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82398 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

84 D 82398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No.) Southern & Eloise Ave 22 (St.) Hamilton (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore F. Scheffer

(a) Residence No. Southern & Eloise Ave (St.) Hamilton (Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth

6-DATE OF BIRTH (month, day and year): Dec 27 1848

7-AGE: 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Scheffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Theresa Eschenbrenner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Wm F. Scheffer
(Address): Southern & Eloise Ave

15-
Filed ..... 192.... Registrar.

JAN 5 1924 ROBERT R. KRAMER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 5/24

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Jan 5 1924
that I last saw him alive on Jan 4 1924
and that death occurred, on the date stated above, at 8 15 A. M.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Chron Nephritis, Angina Pectoris (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms.

(Signed) Alvin B Lerman M. D
1/5/24 (Address) 718 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	Jan 7, 1923
20-UNDERTAKER.	ADDRESS
Wm Curtis	502 E. Fayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82399

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 Collins Ave St. Irvington Ward)

Registered No.

2-FULL NAME Mary Pauline Eversman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 115 Collins ave St. Irvington Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis V. Eversman

6-DATE OF BIRTH (month, day and year) Feb. 3, 1850

7-AGE. 73 yrs. 10 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Gottlieb Loyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Fredrica Schlipp

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant Louis V. Eversman

(Address) 731 North Fulton ave

15-Filed JAN 6 - 1924 Registrar. ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-4-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923 to Jan 4, 1924, that I last saw h. alive on Jan 2, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Fulminating Colitis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A. Evans M. D

(Address) 1014 N. Carey

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. Jan 7, 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 East Fulton ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cerebral Haemorrhage.

D 82400 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82400

CERTIFICATE OF DEATH. 86-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: No. Mercy Hospt St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick J Kinn

(Residence in Baltimore: No. 602 N Calvert St St.; 10 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) (Day) 1884 (Year)

7-AGE, 43 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) Butte City

9-BIRTHPLACE, (State or Country) Baltimore Co. Md.

PARENTS:
10-NAME OF FATHER, Matthew Kinn
11-BIRTHPLACE OF FATHER, (State or Country) Ireland
12-MAIDEN NAME OF MOTHER, Sarah Kinn
13-BIRTHPLACE OF MOTHER, (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabelle Kinn

(Address) 602 N Calvert St

15-

Filed ..... 192..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3 (Month) (Day) 1934 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured intestine caused by being Struck by a car

8 days ..... yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(Duration) ..... yrs. mos. ds.

(Signed) Wm J. Tilley, M. D.

(Coroner.)

Jan 5 1934 (Address) 16 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place of death about 8 days in the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, Jan 7 1934

20-UNDERTAKER, Martin Fahey & Son — ADDRESS 1827 W North Ave

INSERT R. KRAUTER, [illegible]

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82401

CERTIFICATE OF DEATH.

91-002 D 82401

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 305 S. Schroeder ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kearney

(a) RESIDENCE NO. 305 S Schroeder ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 13, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Emily Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas J Kirby

(Address) 305 Schroeder St

15 Filed ..... 19 .....

JAN 3 - 1924 ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 2, 1924, to Jany 5, 1924, that I last saw h[illegible] alive on Jany 4, 1924, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

arter. Sclerosis

Heart failure

(duration) 2 yrs. — mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Reginald Dick M. D.

1/6, 1924 (Address) 1453 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 8 1924

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82402

CERTIFICATE OF DEATH.

90 D 82402

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N. Central Ave ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernst Carter

(a) RESIDENCE No 2930 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie S. Carter

6 DATE OF BIRTH (month, day, and year) July 4/1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Upholster 085
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Great Yarmouth Norfolk England

PARENTS

10 NAME OF FATHER Daniel D. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norfolk Eng.

12 MAIDEN NAME OF MOTHER Jemima Rackham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk, Eng.

14 Informant Ernst W. Carter
(Address) 2117 Allendale Rd.

15 Filed JAN 6 1924 ROBERT R. KNABE Burial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. ds.

(Signed) J S H Oaer, M. D.
(Coroner.)

Jan 5/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Jan 7 192 24
20 UNDERTAKER John B. Stencel	ADDRESS 1323 N. Carlton St.

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- ... may be properly classified, so that it ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

Watkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82403

99-001 ✓

D 82403

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N Fremont ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Watkins

(a) RESIDENCE. No. 610 N Fremont ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 9 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	—	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harvey R Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Pauline E Abey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harvey R Watkins
(Address) 610 N Fremont Ave

15 Filed JAN 8 1924, 19 Registrar

ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1923, to Jany 5, 1924, that I last saw h[illegible] alive on Jany 4, 1924, and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Resp. Failure

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) — Wesley Cole, M. D.

(Address) 2702 Edmonson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 7 1924

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 82404

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Hubbard Court ST., 5 WARD)

2-FULL NAME William Essex

(a) RESIDENCE No 518 Hubbard Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) Nov 24/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William Essex

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alberta Sprigg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant William Essex
(Address) 518 Hubbard Ct.

15 Filed JAN 6 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia- (Primary)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collier, M. D.
(Coroner.)
....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 6. 1924
20 UNDERTAKER Mrs Joseph F. Lock	ADDRESS 1302 Pennsylvania Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Unless this certificate is properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 82405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-007 ✓ ✓

D 82405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 E. Centralave ST., 9 WARD)

2-FULL NAME Henry J. Freund

(a) RESIDENCE NO. 1304 E Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Catherine Freund

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 74 Months Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Joseph Freund

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Reichert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Catherine Freund 1304 E Centralave

15 Filed JAN 6 1924, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 4, 1924, that I last saw him alive on Jan 4, 1924, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ? yrs. ? mos ds.

CONTRIBUTORY (Secondary) Cataract

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical sign

(Signed) L. M. C. Cohen, M. D.

, 1927 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Lodge Redemption — DATE OF BURIAL: Jan 8. 1923

20 UNDERTAKER: Wendel & Pippel (Inc) — ADDRESS: 37 Hanover St

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Alcoholic

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82406

100-001 ✓

CERTIFICATE OF DEATH.

D 82406

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 412 S Fifth St. No) (St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Robert Huber

(a) Residence No. 412 S Fifth St. (St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6-DATE OF BIRTH (month, day and year) Sept 1, 1922

7-AGE: ..... yrs. 4 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore Md

(State or Country).....

PARENTS.

10-NAME OF FATHER, William Robert

11-BIRTHPLACE OF FATHER (city or town)..... Baltimore Md

(State or Country).....

12-MAIDEN NAME OF MOTHER, Emily Cruikshank

13-BIRTHPLACE OF MOTHER (city or town)..... Carroll Co Md

(State or Country).....

14-

(Informant)..... William J. Huber

(Address)..... 412 S. Fifth St.

15-

Filed....., 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Jan 3, 1924, that I last saw h. alive on Jan 3, 1924, and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) ..... M. D.

, 19 (Address) 2303 Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Carmel	Jan 6, 1924
20-UNDERTAKER,	ADDRESS
Wendell Dippel & Son	378 Pennsylvania

in plain terms, so that it may be properly classified. See instructions on back of certificate.

JAN 1924 HARRY S. KRAUTER

Spec.—6-9-19—H. P. Co.—1000 Blks.

Vincenza

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82407

CERTIFICATE OF DEATH.

57 D 82407

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 302 S High St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincenza DiGioachino

(a) RESIDENCE. NO. 302 S High St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph DiGioachino

6 DATE OF BIRTH (month, day, and year) May 4. 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54.	4.	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Serafino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Martha Catina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Pete DiGioachino
(Address) 302 S High St

15 Filed JAN 6 - 1924, 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Jan. 5, 1924, that I last saw h.r alive on Jan 5, 1924, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis
Diabetes Mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocard. Dig — a few weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Chemical Analysis

(Signed) Thomas Artigiani M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	Jan 8 1924
20 UNDERTAKER	ADDRESS
Wendel Hoppe & Son	37 Lund St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D 82408

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2017 Portugal St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Staniewicz

(a) Residence No. 2017 Portugal St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	—

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 8, 1923,

7-AGE. X yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Peter John Staniewicz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Bertha Sabaj

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Peter J. Staniewicz

(Address) 2017 Portugal St.

15- Filed, JAN 6 1924, 192..., Registrar. Edward R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1923 to Jan. 4, 1924, that I last saw him alive on Jan. 4, 1924, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Kager, M. D.

1/5, 1924 (Address) 2627 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, [illegible] Staniewicz | DATE OF BURIAL, ..., 1924

20-UNDERTAKER, Wm. Galfpowski | ADDRESS 618 Eastern

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 82409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital (Ward) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Gurbelski

(a) RESIDENCE NO 619 S. Montford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Gurbelski

6 DATE OF BIRTH (month, day, and year) Jan 6/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mfg'r.
(b) General nature of industry, business, or establishment in which employed (or employer) Bottling- Soft Drinks
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Gurbelski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Chmiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Victoria Gurbelski
(Address) 619 S. Montford

15 Filed JAN 6 1924 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis or Ulcer

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism- acute (duration) yrs. mos. ds.

(Signed) J. S. H. Pearce, M. D. (Coroner.)

Jan 6/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	1/9 1924
20 UNDERTAKER	ADDRESS
William Fiedler	1418 E. Eager

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- ...ch may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82410

CERTIFICATE OF DEATH.

202 D 82410

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME R. Bartlomiej Lisek.

(a) RESIDENCE No. 2817 Fait Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced, WIFE (or HUSBAND) of Magdalena Lisek.

6 DATE OF BIRTH (month, day, and year) July 21, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Napmocyn Lisek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Katie Werner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Magdalena Lisek (wife)
(Address) 2817 Fait Ave.

15 Filed JAN 3 1924, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries.
Crushed about the body by falling lumber. Accidental Death.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jany. 5, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Accident at Fairfield, Jany. 3, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL B. Baltimore

DATE OF BURIAL 1/7 192 4

20 UNDERTAKER L. J. Piaskowski 1000 E. Fayette

ADDRESS Removed

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- ...may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 82411

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 82411

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2943 Hudson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Estremski

(a) RESIDENCE NO. 2943 Hudson ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 31-1923

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	X	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Stanislaus Estremski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Rogus

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Stanislaus Estremski
(Address) 2943 Hudson St

15 Filed ..... 19.. Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 5, 1923, that I last saw him alive on Jan 5, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Famiglietti M. D.

1/5, 1924 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 7 1924
20 UNDERTAKER	ADDRESS
Stephen Fialkowski	1008 Fleming Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 82412

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 131 E. North Avenue St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte A. Robinson

(a) Residence No. 131 E. North Avenue St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of L. Bayard Robinson

6-DATE OF BIRTH (month, day and year) June 10, 1857

7-AGE. 66 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: William S. Crook

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md.

12-MAIDEN NAME OF MOTHER: Esther Huffington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Md.

14-(Informant) L. Bayard Robinson

(Address) 131 East North Ave.

15-Filed JAN 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. X 1923 to Jan. 3 1924

that I last saw h[illegible] alive on Jan. 3 1924

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

Arter.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs & symptoms

(Signed) L. T. Shemwell M. D

Jan. 5, 1924 (Address) 2226 Madison ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cemetery	1/7/23 19 24
20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *scpticemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cerebral Haemorrhage

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82413

CERTIFICATE OF DEATH.

101-06 D 82413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Church St. ST., 22 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Frazier. (C)

(a) RESIDENCE No 16 W. Church St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Widow.

5a If married, widowed, or ~~divorced~~ (or) WIFE of James Frazier. (C)

6 DATE OF BIRTH (month, day, and year) January 17 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Asaac Cannon. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ellen Prattis. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Viola Lee. (C) daughter.
(Address) 140 N. York St.

15 Filed JUN 6 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner.), M. D.

Jany. 5, 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 7 192 4
20 UNDERTAKER	ADDRESS 1400
Brown & Sheridan	Division St

IMPORTANT is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

D 82414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 179

D 82414

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 941 Sarah ann St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Alice Robinson

(Residence in Baltimore: No. 941 Sarah ann St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

6-DATE OF BIRTH. Dont Know (Month) (Day) 1..... (Year)

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). Dont know

12-MAIDEN NAME OF MOTHER. Alice Dorsey

13-BIRTHPLACE OF MOTHER, (State or Country). Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Alderson

(Address) 941 Sarah ann St.

15-

Filed ....., 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 3 (Day) 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration)..... yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration)..... yrs. mos. ds.

(Signed) ..... M. D. (Coroner.)

192.... (Address) .....

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn — DATE OF BURIAL, Jan 7, 1924

20-UNDERTAKER, Brown and Freeland — ADDRESS 114 Schroeder St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82415

CERTIFICATE OF DEATH.

1/4 D 82415

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N London Ave St., 20 WARD)

2-FULL NAME Caroline Frankamp

(a) RESIDENCE NO. 415 N London Ave St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Frankamp

6 DATE OF BIRTH (month, day, and year) Dec 1 1851

7 AGE Years 72 | Months 5 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Theodore Steinhage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Helzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mr August Frankamp 415 N London

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 4, 1924, that I last saw h[illegible] alive on Jan 4, 1924 and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation from hours

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex

(Signed) J. M Lamberson, M. D.

1924 (Address) 426 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem | DATE OF BURIAL 1/7 1924

20 UNDERTAKER George C Jacky Fulton Ave | ADDRESS .....

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82416

CERTIFICATE OF DEATH.

3 D 82416

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2036 Gough St. ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie V. Welsh

(a) RESIDENCE No. 2036 Gough ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Frank Welsh

6 DATE OF BIRTH (month, day, and year) Sept. 7. 1895

7 AGE: Years 28; Months ~~Sept~~; Days 7

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Frank Welsh

(Address) 2036 Gough St.

15 Filed JAN 7 - 1924 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1923 to Jan 4, 1924 that I last saw her alive on Jan 3, 1924 and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tubs — Cutosis about 3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Welsh, M. D.

1-5: 1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Jan 7th 1924

20 UNDERTAKER: J. F. Moran — ADDRESS 3000 E. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16T-001
16T D 82417

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Eisler ST., 22 WARD)

2-FULL NAME Solon Stewart

(a) RESIDENCE No. 519 Eisler ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Stewart

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mother (Address) 519 Eisler St.

15 Filed ..... 19..... Registrar

JAN 7 1924 ROBERT R. KRAMER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19th, 1923, to Jan. 4th, 1924, that I last saw him alive on Jan. 4th, 1924 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Insanition

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Prematurity 37 wks.

Burns (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis H. Douglass, M. D.

1-5-1924 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-7- 1924

20 UNDERTAKER Levi Eastern

ADDRESS 916 Penna ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82418

CERTIFICATE OF DEATH.

16 1-001 D 82418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Eisden ST., 22 WARD)

2-FULL NAME Henry Stewart

(a) RESIDENCE NO. 519 Eisden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. Baltimore

PARENTS

10 NAME OF FATHER Samuel Stewart

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mother (Address) 519 Eisden St.

15 JAN 7 1924 ROBERT R. KRAUTER, Registrar

Filed ....., 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19th, 1923, to Jan. 4th, 1924, that I last saw him alive on Jan. 4th, 1924, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Insanity Fits

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth 37 wks.

Twin (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis H. Douglass, M. D.

1-5, 1924 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL 1-8 1924

20 UNDERTAKER David Foster

ADDRESS 916 Cathedral

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82419

CERTIFICATE OF DEATH.

160

D 82419

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Snyder

(a) RESIDENCE No. 1820 Jackson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER Samuel Snyder

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret Pepper

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs. Margaret Snyder (Address) 1820 Jackson St.

15 Filed JAN 7 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27- 1923, to January 6, 1924, that I last saw him alive on January 6, 1924, and that death occurred, on the date stated above, at 6-15 A.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Jan 8 1924
20 UNDERTAKER John F. Conway & Son per F.F. Conway	ADDRESS 901 Hollins St.

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82420

D 82420

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Arlington St (Gorsuch) ST., 7 WARD)

2-FULL NAME Laura Virginia Grape

(a) RESIDENCE No. 514 Arlington St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MAGE should be stated EXACTLY. PHYSICIANS should state
that it may be properly classified. Exact statement of OCCUPA-
s on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Henry Evans Grape

6 DATE OF BIRTH (month, day, and year) June 4th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Samuel A Horry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant David Millard (Address) Hamlin Apts.

15 Filed JAN 7 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923, to Jan 4, 1924, that I last saw her alive on Jan 4, 1924 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H W Wheaton, M. D.

, 19 (Address) 4239 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 1/7.24 19

20 UNDERTAKER H. E. Hughes. 424 N. Broadway — ADDRESS

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-801 V

82421

CERTIFICATE OF DEATH.

D 82421

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. (Sieber) ST. 6 WARD)

2-FULL NAME Estelle Seifert

(a) RESIDENCE NO. 417 W. Streeper St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Since ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Seifert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Frauke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 7 1924 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1923, to Jan 4, 1924, that I last saw her alive on Jan 4, 1924, and that death occurred, on the date stated above, at 6 30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Otitis Media

(duration) ..... yrs. ..... mos 13 da.

CONTRIBUTORY (Secondary) Vomiting + Diarrhoea

(duration) ..... yrs. ..... mos. 13 da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) H. N. Beech, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan. 7 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH is very important. See instructions on back of certificates. TION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82422

CERTIFICATE OF DEATH.

D 82422

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 E. Lombard ST., V WARD)

2-FULL NAME Mary C. Nambach

(a) RESIDENCE No. 1918 E. Lombard St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Nambach.

6 DATE OF BIRTH (month, day, and year) Aug 24 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John F. Schaefer.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Catherine C. Kues
(Address) 1926 E. Lombard St

15 Filed JAN 7 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1924

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to Jan 4, 1924, that I last saw h[illegible] alive on Jan 3, 1924, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

duration 1 yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

duration 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Keller, M. D.

J. 6. 1924 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Jan. 7 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82423

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

3 | D 82423

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S. Collington Ave ST., 1 WARD)

2-FULL NAME Agnes Weisner

(a) RESIDENCE No. 514 S. Collington Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11 - 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Weisner

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Braun

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant
(Address) Joseph Weisner 514 S. Collington Ave

15 Filed JAN 7 1924, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Jan 5, 1924,
that I last saw her alive on Dec 28 1923
and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory (duration) 3 yrs. 3 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W Schneider, M. D.

, 19 (Address) 2015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan. 8 1924
20 UNDERTAKER	ADDRESS
Tilly & Zeiler	1403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 82424

CERTIFICATE OF DEATH.

D 82424

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 624 Mc Cabe Cor St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lelia Rutherford

(a) Residence No. 624 Mc Cabe Cor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 19, 1923

7-AGE. ..yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or...min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto

(State or Country),

PARENTS.

10-NAME OF FATHER, Walter Rutherford

11-BIRTHPLACE OF FATHER (city or town) Va

(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Shirk

13-BIRTHPLACE OF MOTHER (city or town) Md

(State or Country),

14- (Informant) Walter Rutherford

(Address) 624 Mc Cabe Cor

15- Filed JAN 7 - 1924 Reg. No. ROBERT R. KRAMER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 1924 to Jan 7 1924

that I last saw h[illegible] alive on Jan 7 1924

and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Premature Child

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter C Bacon M. D

1/7/24 (Address) 100 E 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cremation DATE OF BURIAL, Jan 7 1924

20-UNDERTAKER, Wm Cook ADDRESS 502 E St Cor

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82425 D 82425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 113

City of BALTIMORE (No. 313 Patapsco St., 75 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Burns

(a) Residence No. 313 Patapsco St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar'd

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-5-23

7-AGE, ...yrs. 1 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo. W. Burns

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.

12-MAIDEN NAME OF MOTHER, Cora F. Scarton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Geo W. Burns

(Address) 313 Patapsco St.

15-

Filed ....., 192.... Registrar.

JAN 7 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1924, to Jan. 5, 1924, that I last saw h.. alive on Jan. 5, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Erkenbrecher, M. D.

Jan. 6, 1924 (Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Easton Md — DATE OF BURIAL, 1/7, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1538 D 82426

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Lorman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Rich

(a) RESIDENCE. No. 1603 Lorman ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Kenbridge (State or country) Va

PARENTS

10 NAME OF FATHER Jas. Callahan

11 BIRTHPLACE OF FATHER (city or town) Kenbridge (State or country) Va

12 MAIDEN NAME OF MOTHER Doug Schallman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Rankne (Address) Washington D C

15 Filed JAN 7 1924 19 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1923, to Jan 4, 1924, that I last saw h[er] alive on Jan 4, 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Endocarditis and Renal Arthritis

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jno Kuster, M. D.

, 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kenbridge Va	Jan 6, 1924

20 UNDERTAKER James H Dennis. ADDRESS 1803 Brentwood

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *sepsis*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis
Probably.

Spec.—1-10-21—M&T—1500 Bks.

D 82427

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 D 82427

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 19 WARD)

2-FULL NAME Mary Jackson (Purvey)

(a) RESIDENCE NO. 259 N. Bruce st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jackson

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Crockett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Katie Parlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed ..... 19 ..... Registrar

JAN 7 1924 Registrar & Ex-Officio Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1923, to Jan. 3, 1924, that I last saw her alive on Jan. 3, 1924, and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Lally, M. D.

1-3-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	1/7 1924
20 UNDERTAKER	ADDRESS
James H. Dennis	1803 Pleasant

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 82428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 82428

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 806 S. Ellwood St. (WARD)

2-FULL NAME Patrick Welch

(a) RESIDENCE No. 806 S. Ellwood ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Welch

6 DATE OF BIRTH (month, day, and year) Oct. 18 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	2	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Anna Welch
(Address) 1155 S. Baldwin

15 Filed JAN 7 - 1924 1924 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Thos. H. Bu. Horton M. D.
(Coroner.)

Jan 5th 1924 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Jan 7 1924

20 UNDERTAKER Finkler & Finkler

ADDRESS 1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82429

CERTIFICATE OF DEATH.

+ 90

D 82429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 51 Forrest View Ave. (St.) Belmar (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Lowery

(a) RESIDENCE NO. 51 (Usual place of abode) Forrest View Ave ST., WARD Tilghmans Island Md (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? 78 yrs. 10 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late James E. Lowery

6 DATE OF BIRTH (month, day, and year) Feb 11/45

7 AGE — Years: 78 Months: 10 Days: 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant. (Address) Capt Elmer F. Lowery Tilghmans Island Md

15 Filed JAN 7 - 1924 ROBERT A. KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/1, 1923 to 1/6, 1924, that I last saw h[e] alive on 1/6 1924 and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myo Cardital

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Rauch, M. D.

, 19 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tilghman's Island — DATE OF BURIAL: 1/7 1924

20 UNDERTAKER Talbott Co Md — ADDRESS 2016 Orleans St

Philip Herwig

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 82430

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. Guilford Av. cor 21st ST., 17 WARD)

2-FULL NAME Mary Louise Hamburg

(a) RESIDENCE NO. Guilford Ave. cor 21st ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, ~~HUSBAND~~ (or) WIFE of late George Hamburg

6 DATE OF BIRTH (month, day, and year) Apr 8/53

7 AGE — Years: 70 — Months: 8 — Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired old

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Geo. Reinig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mrs James G. McCollister
(Address): 26 Bayonne ave.

15 Filed ....., 19.....

Registrar

JAN 7 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1923, to Jan 4th 1924, that I last saw her alive on Jan 4th 1924 and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ..... yrs. ..... mos. one ds.

CONTRIBUTORY (Secondary) Cystitis & Colitis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? no Date of "

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. N. Gabriel, M. D.

1/4, 1924 (Address) 2413 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: 1/7 1924

20 UNDERTAKER: Phil. Herwig

ADDRESS 2014 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82431

CERTIFICATE OF DEATH.

3/✓ D 82431

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. 2 Cedar St, Curtis Bay ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August E. Remmers.

(a) RESIDENCE No 1640 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Elizabeth Remmers.

6 DATE OF BIRTH (month, day, and year) May 9, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Shore keeper.
(b) General nature of industry, business, or establishment in which employed (or employer): 0&6
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Henry Remmers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Christine Drescher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Louise Archibald. (sister)
(Address) 1640 Hanover St

15 Filed JAN 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January, 5, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhard, M. D.
(Coroner.)

Jan, 5, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 7 1924
20 UNDERTAKER	ADDRESS
A. Bouvard Evans	1428 E. Baltimore

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

S. A. E.

Spec.—1-10-21—M&T—1500 Blks.

D 82432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82432

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Peach alley ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry Taylor

(a) RESIDENCE NO. 1002 Peach alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col.	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Taylor

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Viola Taylor

(Address) 1002 Peach alley

15 Filed JAN 7 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2 1923, to Jan 3rd 1924, that I last saw him alive on Jan 2nd 1924, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. 9 mos and ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E E Burton, M. D.

1/6, 1924 (Address) 309 E. Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	1/7 1924
20 UNDERTAKER Edmund L Brady	ADDRESS W Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OOD DAK

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82433

CERTIFICATE OF DEATH.

101-001 D 82433

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3109 Elliott ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Neisser

(a) RESIDENCE NO. 3109 Elliott ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 72	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Neisser Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James N. Neisser
(Address) 1920 E. Fayette St

15 Filed JAN 7 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)
Jan 6 1924 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Md

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greus, Sterners Run	Jan 8 1924
20 UNDERTAKER	ADDRESS
Geo M. Frank & Son	811 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82434

CERTIFICATE OF DEATH.

74-001

D 82434

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, 10 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alexander Wilson

(a) Residence No. Preston & Valley ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1842

7-AGE. 82 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. Alexander Wilson

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Annie ~~Jones~~

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country). Baltimore

14- (Informant) Sister Superior

(Address) Preston & Valley

15- Filed ..... 192 ..... Registrar.

JAN 7 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 6/24

17- I HEREBY CERTIFY, That I attended deceased from No record 19..... to ..... 19.....

that I last saw h. alive on ..... 19.....

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

Jan 6/24 (Signed) F. A. Warner, M. D

, 192 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Catholic Cem — DATE OF BURIAL. 1/8/24 19....

20-UNDERTAKER. P. C. Weatherholt — ADDRESS Towson

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82435

CERTIFICATE OF DEATH.

X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lanier Williams

(a) RESIDENCE No. 90 S. Pryor St, Atlanta ST., WARD Atlanta, Ga

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Tucker Williams

6 DATE OF BIRTH (month, day, and year) Mar 31, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John T. Williams (D)

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina (D)

12 MAIDEN NAME OF MOTHER Mary Somerville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Lula T. Williams (Address) Atlanta Ga.

15 Filed JAN - 1924 Registrar ROBERT P. KRAUTER

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 Jan 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1923, to Jan. 5, 1924, that I last saw him alive on Jan 5, 1924 and that death occurred, on the date stated above, at 8.10 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/5. 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Knoxville Tenn DATE OF BURIAL Jany 7. 1924

UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

NOTICE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2412 N. Colvert St., 17 Ward)

2-FULL NAME Maria D. Welsh

(Residence in Baltimore: No. 2412 N. Colvert St. 60 yrs., mos., ds.)

1 29 D 82436

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: Sept. (Month) 6. (Day) 1837 (Year)

7-AGE: 86 yrs. 4 mns. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): V. A.

PARENTS.

10-NAME OF FATHER: Palmer Sherry

11-BIRTHPLACE OF FATHER, (State or Country): N. Y.

12-MAIDEN NAME OF MOTHER: Cathrine Study

13-BIRTHPLACE OF MOTHER, (State or Country): Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie S. Welsh

(Address) 2412 N. Colvert St

15- Filed JAN 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 6. (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia, Cancer
Cyst - Interstitial
No Physician

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Morrison M. D. (Coroner.)

Jan 7 1924 (Address) 912 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan. 8, 1924

20-UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82437

CERTIFICATE OF DEATH.

10 D 82437

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lydenham Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME albert Buhlmaly

(a) RESIDENCE NO. 335 Futhill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 6-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis Buhlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Fairchild

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto- Md

14 Informant Louis Buhlman (Address) 335 Futhill Ave

15 Filed JAN 7 1924 ROBERT R. KRAUTER, Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1923, to Jan 7, 1924, that I last saw him alive on Jan 6, 1924, and that death occurred, on the date stated above, at 5:59 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal + pharyngeal.

(23)

(duration) — yrs. — mos. 23 ds. (?)

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 23 ds. (?)

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? cultures (+)

(Signed) Bulgelman, M.D.

19 (Address) Lydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 1/7 1924

UNDERTAKER Mr. Wm A. Frahm

ADDRESS W Pratt

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82438

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 82438

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 801 Power St ST., 13 WARD)

2-FULL NAME Mary A Hewitt

(a) RESIDENCE NO. 801 Power St ST., ... WARD .....

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (Husband of) (or) WIFE of: the late William C Hewitt

6 DATE OF BIRTH (month, day, and year): Oct 14, 1845

7 AGE: Years 78; Months 2; Days 22; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Richard Arpet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md Brown

12 MAIDEN NAME OF MOTHER: Lambert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: Marshall Haynes

(Address): 80 Power St

15 Filed JAN 7 - 1924, 19.... ROBERT B. KRANTZ Registrar

Rudolf Perrott, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 6, 1924

that I last saw her alive on Jan 6, 1924

and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Blood & eyes

(Signed) E. F. Cullen, M. D.

1-7-24 (Address) 2701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hamsfield — DATE OF BURIAL: Jan 24

20 UNDERTAKER: A S Marshall — ADDRESS: 2539 Fall Road

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82439

D 82439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 733 Linden Gengs Ave. WARD 17)

2-FULL NAME Celia Saunders

(a) RESIDENCE NO. 733 Linden Gengs Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

6a If married, widowed, or divorced
HUSBAND of Howard
(or) WIFE of ~~Geo.~~ Saunders

6 DATE OF BIRTH (month, day, and year) about 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Howard Chas. Saunders
(Address) 733 Linden Gengs Ave.

15 Filed ..... 192 ..... Registrar
Robert F. Harrison,
Burial Permit Clerk.

N7 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said the (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hemsley M. D.
(Coroner.)

Jan 5, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem	Jan 8 1924
20 UNDERTAKER John H Owens	ADDRESS 538 Dolphin

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82440

B 82440

CERTIFICATE OF DEATH.

× 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mazie Cofman

(a) RESIDENCE NO. St. Lukes Lane, Woodlawn ST. WARD Md. Woodlawn Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Separated from Husband

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23 Years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Addie Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Patient.
(Address)

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Vital Record Clerk.

N7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 18, 1923, to Jan 6, 1923

that I last saw her alive on Jan 6, 1923

and that death occurred, on the date stated above, at 6.20 a m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & Xray

(Signed) L. A. Lally, M. D.

, 19 (Address) Municipal TB. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Md	1/8 1923
20 UNDERTAKER	ADDRESS
Thos F Kelly & Sons	1318 Eutaw St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be plain and legible. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82441

D 82441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Roland Park

Registered No.....

City of BALTIMORE: (No. 414 Woodlawn Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Mc Lean

(a) Residence No. 414 Woodlawn Road St., Roland Park Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-~~Single~~, ~~Married~~ Widowed, or ~~Divorced~~, (~~Write the word.~~): Widow

5a-If ~~married, widowed, or divorced~~ HUSBAND ~~of~~ (or) WIFE of James Robert Mc Lean

6-DATE OF BIRTH (month, day and year): Oct 9, 1857

7-AGE: 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Canada

PARENTS.

10-NAME OF FATHER: John McMurchy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12-MAIDEN NAME OF MOTHER: Flora McClaus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14- (Informant): Flora Cummings

(Address): 414 Woodlawn Rd

15-

Filed ..... Robert P. Harrison, Registrar.

1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 6-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1923 to Jan 6 1924

that I last saw h~~e~~r alive on Jan 6 1924,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovarian extending to broad ligaments.

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) metastasis to Lungs and Stomach (Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 22-'23

Was there an autopsy? No

What test confirmed diagnosis? Section examined

(Signed) John S. Bishop M. D

Jan 7, 1924 (Address) 930 N. Calvert St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Ontario, Canada — DATE OF BURIAL: Jan 9, 1924

20-UNDERTAKER: Wm. Cook for E. Norris — ADDRESS

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 D 82442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kaufman

(a) RESIDENCE NO. 1022 Rutland Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Kaufman

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Collector

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Joseph Kaufman

11 BIRTHPLACE OF FATHER (city or town) Md, (State or country)

12 MAIDEN NAME OF MOTHER Kate ?

13 BIRTHPLACE OF MOTHER (city or town) Md, (State or country)

14 Informant (Address) Hospital Record.

15 Filed JAN 7 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/3/24 19

17 I HEREBY CERTIFY, That I attended deceased from 12/26/23, 19..., to 1/3/24, 19..., that I last saw him alive on 1/3/24, 19..., and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pneumonia Hypostatic

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Dolley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Berkley — DATE OF BURIAL Jan. 8 1924

20 UNDERTAKER William G. Schaeffer — ADDRESS 1816 Monument

JAN 7 1924

Burial Permit Clerk.

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2333 Druid Hill Av. St.; 13 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schmidt

(a) RESIDENCE No. New London Conn. St.; WARD New London Conn,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New London
(State or country) Conn.

PARENTS

10 NAME OF FATHER Geo. Schmidt

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Carver

13 BIRTHPLACE OF MOTHER (city or town) New London
(State or country) Conn.

14 Informant Mo Mary Schmidt
(Address) 2333 Druid Hill Av.

15 Filed JAN 7 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1924, to January 7th, 1924, that I last saw her alive on January 6th, 1924, and that death occurred, on the date stated above, at 11 20 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Pneumonia de veloped 1st Jany 1924.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Convulsion (duration) yrs. mos. 20 min ds.

18 Where was disease contracted if not at place of death? On train

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. A. Smith, M. D.

1/7, 1924 (Address) 1605 N. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL New London Conn — DATE OF BURIAL Jan 8 1924

20 UNDERTAKER Wm Pickell Sons — ADDRESS Montbella

should be stated EXACTLY. PHYSICIANS should state
may be properly classified. Exact statement of OCCUPA-
back of certificates.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobular

Spec.—8-24-14—M. & T.—2000 Blks.

Tyler

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 82444

CERTIFICATE OF DEATH.

57

D 82444

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Fish House Road Mt Pleasant ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas C Tyler

(Residence in Baltimore: No. Fish House Road St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Cald

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) married

6-DATE OF BIRTH, Sept 12, 1875 (Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Tyler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Davis

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Tyler

(Address) West Pt

15- JAN 7 1924 Filed ..... 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923, to January 3 1924, that I saw h.. alive on January 3 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diabetes
Postmortem Heart disease.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Hall M. D.

January 5, 1924 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
West Auburn Cemetery	1-8, 1924
20-UNDERTAKER	ADDRESS
Mrs E. A. Hooper	406 W. Fremont St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82445

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 001

D 82445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 W Hoffman ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Hawkins

(a) RESIDENCE NO. 305 W. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eden Hawkins

6 DATE OF BIRTH (month, day, and year) 10/3/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles County Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Martha Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md

14 Informant Herbert Lewis (Address) 305 W Hoffman St

15 Filed JAN 7 1924, 19 Robert P. Harrison, Registrar

Daniel Parrott Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1924.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1923. to January 5. 1924.

that I last saw her alive on January 5 1924.

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dropsy + Bright Disease (duration) 1 yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. L. W. Kennard, M. D.

1-6 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	1/8 1924
20 UNDERTAKER George & Ruth	ADDRESS 1735 Harford Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Katie Molly

D 82446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home - Infirmary

CITY OF BALTIMORE: (No. 1N Broadway St., 6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted]. Mrs Katie Molly

(a) RESIDENCE NO. 425 E. F St. Ward 2

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czesko Slav

PARENTS

10 NAME OF FATHER Joseph Dwarz

11 BIRTHPLACE OF FATHER (city or town) Czesko Slav (State or country)

12 MAIDEN NAME OF MOTHER Katie Holley

13 BIRTHPLACE OF MOTHER (city or town) Czesko Slav (State or country)

14 Informant Joseph Holley (Address) 425 E. F St Spencer Ave

15 Filed —1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923, to Jan 5, 1924, that I last saw her alive on Jan 5, 1924, and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Pneumonia

Senile Pneumonia,

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene J Luetkemeyer M. D.

, 19 (Address) Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 8 1924
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	1005 S Kenwood Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82447

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S. Fulton Av. ST., 19 WARD)

2-FULL NAME Catherine A. S. Karl.

(a) RESIDENCE No. 116 S. Fulton Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 8. 1852

7 AGE: Years 71 | Months 6 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Petrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Deems
(Address): 116 S. Fulton ave

15 Filed JA 7 - 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 - 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to Inquest, autopsy or inquiry) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchial Consumption

(duration) yrs. mos. 1 ds.

(Signed) Geo Clinton Saddler, M. D.

Jan 5, 1924 (Coroner.) (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 1/8 1924

20 UNDERTAKER: Robert Brockerson

ADDRESS: Cor Calhoun & Fulton

CAUSE OF DEATH IS IN PLAIN TERMS, so that it may be properly classified. Exact statement of state
TION is very important. See instructions on back of certificate. OF PHYSICIANS

Cor.—1-12-23—M&T—100 Blks.

D 82448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 82448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julian Pinkney

(a) RESIDENCE No. 809 Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Quinlan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary Quinlan
(Address) 809 Parrish St

15 Filed ..... 192 ..... Registrar

JAN 7 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheritic Laryngo-Stenosis

after Operation - Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Bailey, M. D.

Jan 5, 1924 (Address) (Coroner.) 1059 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 1-8-1924

20 UNDERTAKER Amos Easton

ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82449

CERTIFICATE OF DEATH.

Registered No. C 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 W. Mulberry St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Blair

(Residence in Baltimore: No. 715 W. Mulberry St. St., 22 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-Single, Married, Widowed or Divorced: Mar'd (Write the word.)

6-DATE OF BIRTH: Don't Know ..... (Month) ..... (Day) ..... 1..... (Year)

7-AGE: 22 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF ~~Father~~ Wm Blair

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER: Annie Duckett

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Brooks

(Address) 715 W. Mulberry St

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Given

N7-1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 6 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

6/7 1924 (Address) 715 W. Mulberry St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Dr Dolan's Farm	1-8-1923
20-UNDERTAKER.	ADDRESS
David Taylor	Balto

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82450

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Dillmans Court ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Hatts

(a) RESIDENCE NO. 170 4 Dillmans Court ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 70

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Milburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Milburn
(Address) 1704 Dillmans Court

15 Filed ... 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1924

17

I HEREBY CERTIFY, That I attended deceased from July 15 1923 to Jan. 5 1924.

that I last saw her alive on Jan. 2 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James M Harper, M. D.

6/5 1924 (Address) 513 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1-8- 1924

20 UNDERTAKER David Corbin — ADDRESS 716 Cathedral

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
TION is very important. See instructions on back of certificates.

N 1924 Robert P. Garrison, Local Registrar

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82451 113 D 82451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 E. North Ave ST. 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Giles Schmidt

(a) RESIDENCE NO 2221 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 18/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Urei Eda Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John Schmidt

(Address) 2221 E. Noerth Ave

15 Filed JAN 7 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6/2492

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ProblyAcute Gastro-intestinal Indigestion.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J S H Pollitt, M. D. (Coroner.)

Jan 7/2492 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 8 1923
20 UNDERTAKER	ADDRESS
F. A. Frances Son	1039 Fayette St

IMPORTANT is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82452

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D 82452

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 31 S Amm St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Doris Kramer

(a) Residence No..... 31 S Amm St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 24 1923

7-AGE, ...yrs. 3 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Jers L Kramer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Eva Pelzer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14-
(Informant) Jers L Kramer
(Address) 31 S Amm St

15-
Filed ... JAN 7 1924 ..., 192... Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 6 1924

17- I HEREBY CERTIFY, That I attended deceased from January 3 19 24 to January 6 19 24
that I last saw h. alive on Jan. 6 19 24
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) endocarditis,

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. A. Januszeski M. D.

1/7, 19 27 (Address) 2431 Fait A

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	January 8 1924
20-UNDERTAKER.	ADDRESS
Wendell Dyffel & Co	378 Amm St

In plain terms, so that it may be properly classified. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

W Blue 13 Bayley

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82453

CERTIFICATE OF DEATH.

70 D 82453

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 3 WARD)

2-FULL NAME Jennie Herold.

(a) RESIDENCE No. 28 S. Broadway ST., WARD.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE: 36 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Marker

(c) Name of employer Shirt factory Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Geo. Herold

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Jennie Merdel

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Hospital Records.

(Address)

15 Filed ....., 19 Robert P. Harrison.

Registrar

NT - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/2/24, 19..... to 1/2/24, 19....., that I last saw h~~e~~ alive on 1/2/24, 19....., and that death occurred, on the date stated above, at 9a, m.

The CAUSE OF DEATH* was as follows:

Cerebellar abscess

(duration) 3 weeks. yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-Respiratory failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) L. W. Holly, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Jan 9 1924

20 UNDERTAKER: Wendell Dyffel & Son

ADDRESS 378 Penn

IMPORTANT—Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82454

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. Duncan ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Butler

(a) RESIDENCE NO. 511 N Duncan ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (Write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Butler

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 38; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Joseph Gregor

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Wilhelmina Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Wilhelmina Green

(Address): 511 N Duncan St

15 Filed JAN 8 1924, 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 19 24

17

I HEREBY CERTIFY, That I attended deceased from Nov, 19 23, to Jan 5, 19 24,

that I last saw h.. alive on Jan 4 19 24,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Congestion (Pleurisy, Tuberculosis) (Duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) ....., M. D.

, 19 (Address) 14 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Jan 8 1924

20 UNDERTAKER: Edward Bryon

ADDRESS 631 Carlton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 82455

D 82455

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 21 N. Spring St ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Walker

(a) RESIDENCE NO. 21 N. Spring St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct., 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Askins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louis Walker (bro)
(Address) 1714 Pressbury St.

15 Filed JAN 6 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (Lobar)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Fallin, M. D.
(Coroner.)

Jan 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 8 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82456

CERTIFICATE OF DEATH.

D 82456

1-PLACE OF DEATH 233 N. Lafayette Ave

CITY OF BALTIMORE. (No. ..... ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Lockwood Patten

(a) RESIDENCE NO. Fredericksburg, Va. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 wks mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Mr. Antony Patten
WIDOWED

6 DATE OF BIRTH (month, day, and year): 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fredericksburg. Va.

PARENTS

10 NAME OF FATHER: John Coakley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredericksburg, Va

12 MAIDEN NAME OF MOTHER: Elizabeth Thom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fredericksburg. Va.

14 Informant (Address): Mrs. Charles Sinclair 233 N. Lafayette Ave.

15 Filed JAN 8 - 1924, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1924

17 See other side of this certificate

I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..,

that I last saw h... alive on ....., 19..,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

unknown
(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

Jan 7th 1924 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fredericksburg Va	1-8-1924

20 UNDERTAKER: Henry W. Jenkins Son

ADDRESS: Orchard & McCulloh Sts

INSTRUCTIONS. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82457

CERTIFICATE OF DEATH.

44 D 82457

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 213 W. Center ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Camille McGuire

(a) RESIDENCE. No. 213 W. Center ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced (write the word)~~
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	50	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rochchild

9 BIRTHPLACE (city or town) Cumberland, Md.
(State or country)

PARENTS

10 NAME OF FATHER Phillip McGuire

11 BIRTHPLACE OF FATHER (city or town) N. Y. City
(State or country)

12 MAIDEN NAME OF MOTHER Bessie McGraw

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mary M. Garrison
(Address) 213 W. Center

15 Filed JAN 8 - 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1923, to Jan. 6, 1924, that I last saw her alive on Jan 6, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray - Exam. Sp.

(Signed) Frank N. Ogden, M. D.

Jan 7, 1924 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Peter Cem	1-9 192[illegible]

20 UNDERTAKER Stevenson Jenkins Sons Co

ADDRESS Orchard

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82458

CERTIFICATE OF DEATH.

100-091 D 82458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 Edmondson Ave. ST., 16 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Brunner

(a) RESIDENCE NO. 1204 Edmondson Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21 1923

7 AGE — Years: — Months: 6 Days: 16 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John A Brunner
11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Mary M Wahlers
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John A Brunner
(Address): 1204 Edmondson Ave

15 Filed JAN 8 - 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924 to Jan 6, 1924.
that I last saw her alive on Jan 6, 1924,
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Usual
(Signed) Edgar L Towers, M. D.
19 (Address) 1520 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem
DATE OF BURIAL: 1/10 23

20 UNDERTAKER: Gayle Funeral Parlors
ADDRESS: 1 Fayette

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82459

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 82459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincents Infant Asy ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Clark.

(a) RESIDENCE NO. 1411 Division ST ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) University Hosp.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lucille Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant St Vincent Inf Asylum

(Address) 801 Division ST

15 Filed JAN 8 - 1924 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to Jan 4, 1924

that I last saw him alive on Jan 4, 1924

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldthwaite, M. D.

, 19 (Address) 2928 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Jan 9 1924
20 UNDERTAKER	ADDRESS
Chas. H. Bern	1024 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82460

74-001

D 82460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 19 N Pobplestow St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Emma C. Edmondson

(a) Residence No. 19 N Pobplestow St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Mar 21, 1875

7-AGE: 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Wayne Va

PARENTS.

10-NAME OF FATHER: Thos J Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Susan Wallace

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14- (Informant): Mrs M Edmondson

(Address): 19 N Pobplestow St

15- Filed JAN 8 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 6/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923 to Jan 6, 1924

that I last saw h alive on Jan 6, 1924

and that death occurred, on the date stated above, at 1-50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary): Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

Jan 8, 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Wilson Park

DATE OF BURIAL: Jan 9 1924

20-UNDERTAKER: Jos J Smith

ADDRESS: 1005 W Fayette

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82461

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 813 Stricker St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Fanny Handy

(a) Residence No. 813 Stricker St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	Col	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 8 1899

7-AGE,	If LESS than 1 day,
24 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thomas Handy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs. Nellie Coleman

(Address) 813 Stricker St.

15- Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

JAN 8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 5/24

17- I HEREBY CERTIFY, That I attended deceased from Aug 11, 1923, to Jany 5, 1924

that I last saw h.. alive on Jany 4, 24,

and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? —

What test confirmed diagnosis? Clinical Exam.

(Signed) Edwin E. Traynor M. D.

1/7, 1924 (Address) 716 Edmondson

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cemetery	Jan. 8, 1924
20-UNDERTAKER,	ADDRESS
Mrs. Kate R Williams	322 N. Schroeder St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82462

CERTIFICATE OF DEATH.

15 129 D 82462

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Cumberland ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George S. Thompson

(a) RESIDENCE. No. 724 Cumberland ST., 2r WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maryland

6 DATE OF BIRTH (month, day, and year) Nov 15 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48 ~~49~~	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Inspector of cans

(b) General nature of industry, business, or establishment in which employed (or employer): Continental Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Calbert M Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza A Hopson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Eliza A Thompson
(Address) 724 Cumberland St

15 Filed JAN 8 - 1924, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 7, 1924, that I last saw h.. alive on Jan 6, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) J Thomas Nelson, M. D.

, 19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Jan 9th 1924

20 UNDERTAKER: Josiah Lepley ADDRESS 1606 W North Ave

MUST be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82463

CERTIFICATE OF DEATH.

179 D 82463

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 Grindall St., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Johnson

(a) RESIDENCE No. 723 Grindall St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aletha Johnson

6 DATE OF BIRTH (month, day, and year) Dec, 25, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer John Crouch.

9 BIRTHPLACE (city or town) Caroline Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Johnson Caroline Co.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Johnson Caroline Co

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Aletha Johnson
(Address) 723 Grindall St

15 Filed ..... 19 .... ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec, 21, 1923, to Jan, 4, 1924, that I last saw him alive on Jan, 4, 1924, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
and Chronic Diffuse
Nephritis —
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine - Positive

(Signed) David Wanchow, M. D.

1/6, 1924 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL 1/8 1924

20 UNDERTAKER Samuel J. Hamsley — ADDRESS Walbrook

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY

Spec.—8-24-14—M. & T.—2000 Bks.

82464

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 b 82464

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Argyle ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie K Hooper

(Residence in Baltimore: No. 1424 Argyle ave St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1880 (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Taylors Island Md.

PARENTS.

10-NAME OF FATHER, Henry Hooper

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Gainby

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Eugenia Hooper (Sister)

(Address) 1424 Argyle ave

15-

Filed ....., 191... ROBERT P. KRAUTER, Registrar.

JAN 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 4 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1923, to Jan 4 1924, that I saw h[er] alive on Jan 4 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

..... (Duration) ..... yrs. ..... mos. 5 days.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Laughlin M. D.

Jan 5, 1924 (Address) 1602 Pulaski Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Taylors Island Md. DATE OF BURIAL, Jan 8, 1924

20-UNDERTAKER Samuel D Handley ADDRESS Middle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 82465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09 D 82465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 McElderry ST., 5 WARD)

2-FULL NAME Eddie Woods

(a) RESIDENCE NO 1421 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Oct 5/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wm. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Silva Cosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: William Woods
(Address): 1421 McElderry St

15 Filed JAN8 - 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia (Primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S H Pollitt (Coroner.), M. D.

Jan 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 8 1924
20 UNDERTAKER	ADDRESS
R C Gross	1405 McElderry

IMPORTANT is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82466

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Brooks

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed , 19 ROBERT R. KRAUTER Registrar

JAN 8 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from October 30, 1923, to January 4, 1924, that I last saw him alive on January 3, 1924, and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Chronic Myocarditis (Degenerative)

Auricular Fibrillation

Myocardial Degeneration

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. [illegible], M. D.

1-4-24 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Jan 8 1924
20 UNDERTAKER John W. Henderson	ADDRESS 1600 E Monument

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Information should be carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82467

CERTIFICATE OF DEATH.

101-001

D 82467

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 N. Fremont — ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eliza Boyd

(a) RESIDENCE. No. 801 N. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Boyd

6 DATE OF BIRTH (month, day, and year) March 12 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mrs Fullerton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Leonard D Boyd

(Address) 319 N. 16 St City

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 — 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1924, to Jan 7 —, 1924, that I last saw h.. alive on Jan 6, 1924, and that death occurred, on the date stated above, at 9 a — m.

The CAUSE OF DEATH* was as follows:

Later pneumonia of pleurisy

Aortic insufficiency

about 5 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation Hyp age

Several years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place above

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Carlton M. Bolt, M. D.

Jan 7. 1924 (Address) 2219 St Paul street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park cemetery	Jan 9th 1924
20 UNDERTAKER H. M. Walker	ADDRESS 723 W Lafayette ave

Registrar

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82468

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 220 W. Madison Street St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Edith May Brown

(Residence in Baltimore: No. 220 W. Madison Street St; yrs. 2 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1897 (Year)

7-AGE. 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE, (State or Country) Hackettstown, New Jersey

PARENTS.

10-NAME OF FATHER, Stewart Brown

11-BIRTHPLACE OF FATHER, (State or Country). Hackettstown, New Jersey

12-MAIDEN NAME OF MOTHER, Bertie Poole

13-BIRTHPLACE OF MOTHER, (State or Country). Hackettstown, New Jersey

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Stewart Brown

(Address) 220 W. Madison St.

15- Filed JAN 8 1924 ROBERT R. KRAUT Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 7 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart 5 minutes

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hennessy M. D. (Coroner.)

1-8 1924 (Address) 2602 Eutaw Pl. Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence 220 W. Madison St.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hackettstown N.J.	Jan 8" 1924
20-UNDERTAKER.	**ADDRESS**
Joseph B. Cook	1003 W. Baltimore

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-09 D 82469

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 107 S. Stricker ST., 19 WARD)

2-FULL NAME George H. Cromwell

(a) RESIDENCE NO. 107 S. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marion K. Eldredge Cromwell

6 DATE OF BIRTH (month, day, and year) Sept 17 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	3.	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pattern Maker B&ORR

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) Piedmont
(State or country) W. Va.

PARENTS

10 NAME OF FATHER Andrew J. Cromwell

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER .

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ind.

14 Informant Mrs Marion K E. Cromwell
(Address)

15 Filed JAN 8 - 1924, 19 ..... Registrar ROBERT R. KRAUT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 15. 1923, to Jany 6, 1924, that I last saw h[illegible] alive on Jany 6, 1924, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Epilepsy -

(duration) 39 yrs — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) W. J. Costello, M. D.

, 19 (Address) 333 E 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 8 1923

20 UNDERTAKER Harry H. Wirtzke — ADDRESS 1531 W Lombard

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T 1505 Blks.

D 82470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82470

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Gray

(a) RESIDENCE NO. 816 W. 37th St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 16 1897

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
26	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 061

(b) General nature of industry, business, or establishment in which employed (or employer) Police Officer

(c) Name of employer Md

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Nuhlan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address)

15 Filed JAN 8 - 1924 ROBERT R. KRAUTER, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/2/24, 19..., to 1/6/24, 19..., that I last saw h alive on 1/6/24, 19..., and that death occurred, on the date stated above, at 12. noon m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

2

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of 1/3/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological

(Signed) K. W. Talley, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Jan 9 1924

20 UNDERTAKER Mrs. John W. Teufel & Son

ADDRESS 80 W. Fayette

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82471

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1631 Abbott St. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizetta C Houck.

(a) Residence No. 1631 Abbott. St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (write word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William H Houck.

6-DATE OF BIRTH (month, day and year) May 13 1866

7-AGE.			If LESS than 1 day,
57 yrs.	7 mos.	23 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Henry Lochmiller.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Amelia Gebhardt.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-

(Informant) William H Houck.

(Address) 1631 Abbott.

15-

Filed JAN 9 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7-1924

17-I HEREBY CERTIFY, That I attended deceased from January 1-24 to January 6-24.

that I last saw h... alive on January 6-24.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration 6 days

CONTRIBUTORY (Secondary) Chronic Nephritis 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? General

(Signed) Thos. B. A. McEy M. D.

1/8, 1924 (Address) 1031 N. Chas

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Jan 9/24 19..
20-UNDERTAKER, John Ullrich	ADDRESS 2008 Orleans

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82472

CERTIFICATE OF DEATH.

D 82472

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 500 N: PPk Ave. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W: Reinhold

(a) Residence No. 500 N: Patterson Park Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the Word.)
Male	White	Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Maria A: Reinhold

6-DATE OF BIRTH (month, day and year) II/I8/ I837

7-AGE.	If LESS than 1 day,
86 yrs. mos. 2I ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dyer

(b) General nature of industry, business, or establishment in which employed (or employer) 027

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Otto Reinhold

(Address) 500 N: Patterson Park Ave

15- Filed JAN 8 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Jan 7, 1924, that I last saw h[illegible] alive on Jan 6, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Arterio - Sclerosis. Chronic Nephritis (Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Leeman M. D.

1/8, 1924 (Address) 718 N Pat Pk ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
20-UNDERTAKER,	ADDRESS.
Oak Lawn Cem	Jan 10, 1924
[illegible]	[illegible]

in plain terms, so that it may be properly classified. See instructions on back of certificates. EXACTLY. PHYSICIANS should state CAUSE OF DEATH ... is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

Nov 6430 Knapp

D 82473 M Cowen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82473 Preston

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 444 East North st. 12th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Cowen

(a) Residence No. 444 East North st. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1846

7-AGE. About 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter Cowan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, Katherine White

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) William H Legg

(Address) 444 East North Ave

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JAN 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923 to Jan 6 1924

that I last saw her alive on Jan 5 1924

and that death occurred, on the date stated above, at 12.45 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Valvular Heart Disease

(Duration) 7 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of Lungs (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hubert C Knapp M. D

Jan 6, 1924 (Address) 1216 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Jan 9 1924
20-UNDERTAKER.	ADDRESS
William Cook	502 E North Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Filled in EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82474

CERTIFICATE OF DEATH.

9 74-006

1-PLACE OF DEATH

City of BALTIMORE: (No. 1016 E. 20th St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Smith

(a) Residence No. 1016 E. 20th St. St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ single

6-DATE OF BIRTH (month, day and year) Sept 27, 1871

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Richard Smith

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Hergesheimer

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Wm. L. Smith

(Address) 1718 N. Fulton Ave.

15-

Filed ..... 192.. .....

Registrar.

NB - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-7-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 19 17 to Jan 7 19 24

that I last saw her alive on January 7 19 24,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. J. Kinsey M. D

1/10 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Ballenson Cemetery	Jan 10, 1924
20-UNDERTAKER.	ADDRESS
Wm. Cook & Son	E. Monument

in plain terms, so that it may be properly classified. See instructions on back of certificates.

~~Signed EXACTLY. PHYSICIANS should state CAUSE OF DEATH~~

Spec.—1-10-21—M&T—1500 Bks.

D 82475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82475

CERTIFICATE OF DEATH.

74001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Hope Retreat ST. 28th WARD)

2-FULL NAME Dadie J. Frantz

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD Cumberland Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 0 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Frantz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	45	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (?)
(State or country) England

PARENTS

10 NAME OF FATHER Richard Johnston

11 BIRTHPLACE OF FATHER (city or town) Wicklow
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget White

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Eng Ireland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Baltimore Md

15 Filed JAN 18 1924, 19.... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 23rd, 1923, to Jan 8, 1924, that I last saw h[illegible] alive on Jan 7, 1924, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Paralysis - (Right Hemiplegia)
(Coma)

Abt (duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Manic Psychosis - Delusional Type - Abt (duration) Abt yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Cumberland Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md

DATE OF BURIAL Jan 8 1924

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Terminal Cerebral Hemorrhage
No Luetic Infection

Spec.—1-10-21—M&T—1500 Bks.

D 82476

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 82476

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 14 WARD)

2-FULL NAME Allan Temple Machen

(a) RESIDENCE NO. 302 N. Carey ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? 0 yrs. 6 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ Single

6 DATE OF BIRTH (month, day, and year) June 11, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child (none)

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Raymond Machen (1)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Olive Hemmer (1)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland Md Md

14 Informant Raymond Machen - (Father)
(Address) 302 N. Carey St

15 Filed JAN 8 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1923, to Jan 6, 1924.

that I last saw him alive on Jan 6, 1924,

and that death occurred, on the date stated above, at 9-40 P. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jay Mart, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan 8 1924

20 UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE.

NOTICE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82477

CERTIFICATE OF DEATH.

D 82477

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 307 S. Exeter ST. 3 WARD)

2-FULL NAME Mary E. Dolan

(a) RESIDENCE NO. 307 S Exeter ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, ~~or divorced~~
~~(Husband) of~~
(or) WIFE of Michael A. Dolan

6 DATE OF BIRTH (month, day, and year) July - 1853

7 AGE: Years 70 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Peter Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire

12 MAIDEN NAME OF MOTHER Stella McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Stella E. Dolan
(Address) 307 S Exeter St

15 Filed ....., 19 .....
Robert F. Harrison
Registrar
~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Jan. 6, 1924.

that I last saw h[illegible] alive on Jan 4, 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ... yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Corcoran, M. D.

1-7-24, 19 (Address) 3m Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL 1/9/24

ADDRESS 3000 E Baltimore

John A. Moran

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82478

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 418 Patapsco ave ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion E. Peter

(a) RESIDENCE No. 418 Patapsco ave ST., 25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Peter

6 DATE OF BIRTH (month, day, and year): Jan 14-1871

7 AGE: Years 52 | Months 11 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter Builder

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): West Va.

PARENTS

10 NAME OF FATHER: Jno Peter

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Virginia

12 MAIDEN NAME OF MOTHER: Annie Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va

14 Informant (Address): Katherine Peter 418 Patapsco

15 Filed ..... 19 Burial Permit Clerk

JAN 8 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Jan 6, 1924

that I last saw h alive on Jan 5, 1924

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Over)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arthritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas H Brooks, M. D.

1924 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral Cem

DATE OF BURIAL: 1/9/24 19

20 UNDERTAKER: J A Doran

ADDRESS 3000 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

D 82479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82479

CERTIFICATE OF DEATH.

14-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD) 25

2-FULL NAME Elizabeth Keltie Norris

(a) RESIDENCE No. 400 Hollins & Sycamore Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 21, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward T. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie S. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant A. Turnbull

(Address) 400 N. Ellen Cator Gold

15 Filed JAN 8 1924, 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 7, 1924

that I last saw her alive on Jan 7, 1924

and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) bronchopneumonia (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at a public library

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 9th 1924
20 UNDERTAKER	ADDRESS
Jerry V. Jenkins & Sons	Orchard & Guilford

Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 82480

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E. Madison ST., 11 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Mc=Cauley

(a) RESIDENCE No. 16 E Madison ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years about 83 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Commodore McCauley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Philg

12 MAIDEN NAME OF MOTHER L. S Dickeman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bland

14 Informant Mrs O. Connell
(Address) 16 E Madison St

15 Filed JAN 8 1924, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1924, to Jany 8, 1924, that I last saw h-e alive on Jany 7, 1924, and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) many yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) Several yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas O'Donovan, M. D.

Jan 8, 1924 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cem Washington Co.	Jan 11 1924
20 UNDERTAKER Henry J Jenkins & Son	ADDRESS 2 E Read St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—500 Blks.

D 82481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82481

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 29 E. Heath St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Emily Winkler

(a) Residence No. 29 E. Heath St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) aug 20. 1904

7-AGE, 19 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer)..... C & P

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Henry P. Winkler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Charles Co. Md.

12-MAIDEN NAME OF MOTHER, Anna Ullman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Austria

14-

(Informant) Mrs. Eiser

(Address) 1412 Patapsco St.

15-

Filed ..... 19.....

Registrar.

NR - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 7. 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923, to Jan 7, 1924, that I last saw h.. er alive on Jan 6, 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

from history Duration One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cronhaus M. D.

Jan 8, 1924 (Address) 3100 Hoafod Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Cross Cem. | DATE OF BURIAL, Jan. 10. 1924

20-UNDERTAKER, Margaret H. Flynn | ADDRESS 1422 Light St.

Instructions: Cause of death must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. Abbreviations should not be used. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. Abbreviations should not be used. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. Abbreviations should not be used. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. Abbreviations should not be used. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. Abbreviations should not be used. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. Abbreviations should not be used. Exact statement of OCCUPATION is very important. AGE should be properly classified. in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82482

CERTIFICATE OF DEATH

D 82482

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. 100-001

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Scott

(a) RESIDENCE NO. 814 Filbert ST., WARD Curtis Bay
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19 1922

7 AGE — Years: 1 — Months: 6 — Days: 10 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Curtis Bay Md

PARENTS

10 NAME OF FATHER: Ernest Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elz. Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ernest Scott
(Address): 814 Filbert St.

15 Date Received: JAN 9 1924

Robert P. Harrison, Registrar

Burial Permit Clerk

N8

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Jan 7, 1924, that I last saw her alive on Jan 7, 1924, and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Pulmonary Edema

Cardiac Dilatation

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (Covers)

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab

(Signed) Jno A Tompkins M. D.

, 19 (Address) 1417 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: Jan. 9, 1924

20 UNDERTAKER: Margaret G. Flynn — ADDRESS: 1422 Eutaw Pl

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of any infectious disease prior.

Primary

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82483

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 ✓ D 82483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1024 Brent St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Johnson

(a) Residence No. 1024 Brent St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Wdw

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. E. Johnson

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer. 070

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo. Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Annie Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Jas E Johnson

(Address) 1124 Brenner St

15-

Filed JAN 8-1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 2nd 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 31 1923 to Jany 2 1924

that I last saw h[illegible] alive on Jany 2 1924

and that death occurred, on the date stated above, at 2 45 m.

The CAUSE OF DEATH* was as follows:

Edema Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Wm. E. Magruder M. D

1924 (Address) 1006 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Lebanon Cem — DATE OF BURIAL. 1-5-24

20-UNDERTAKER. Dent Easter — ADDRESS 916 Oa ave

INSTRUCTIONS. Answer questions EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated CAREFULLY supplied.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Arteriosclerosis

No history

Spec--12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D~~ 82484

CERTIFICATE OF DEATH.

100-09 ✓ 82484

1-PLACE OF DEATH

City of BALTIMORE: (No.) 678 Pine Al St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Cole

(a) Residence No. 678 Pine Al St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 26, 1923

7-AGE, ...yrs. 5 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Cole

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Shenandoah Va

12-MAIDEN NAME OF MOTHER, Martha Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Rockmart Ga

14- (Informant) Mother

(Address) 678 Pine Al

15- Filed JAN 8 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924 to Jan 7, 1924

that I last saw h[illegible] alive on Jan 6, 1924

and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Grippe

(Duration) ....yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H Boas M. D.

, 19 (Address) 53 George St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	1-9- 19..23
20-UNDERTAKER.	ADDRESS
Dud Ferbert	Cem

Instructions: Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82485

CERTIFICATE OF DEATH.

46

D 82485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3923 Roland Ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Gleason

(a) RESIDENCE NO. 3923 Roland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Gleason

6 DATE OF BIRTH (month, day, and year) Aug 8 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at her own home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Co Clare Ireland

PARENTS

10 NAME OF FATHER Michael McNamara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Gleason (husband) (Address) 3923 Roland Ave

15 Filed - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 8 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to Jany 8, 1924, that I last saw h.e alive on Jany 7, 1924, and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Intra Pelvic Cancer.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 25. 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

Jany 8, 1924 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York Staten Island	Jan 9 1924

20 UNDERTAKER	ADDRESS
Ehrenworth Son	3617 Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and undertaker's CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N8

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Items

Cor.—1-12-23—M&T—100 Bks.

D 82486

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Pennington Ave. St., Curtis Bay WARD)

REGISTERED NO. 199

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Fado.

(a) RESIDENCE No 922 Pennington Ave. St., Curtis Bay WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? 35 yrs. ---- mos. ---- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed or divorced (or) WIFE of Stanislaus Fado.

6 DATE OF BIRTH (month, day, and year) September 6, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Antone Gralewsky.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Frances Markowsky.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Stanislaus Fado. (husband)
(Address) 922 Pennington Ave. Curtis Bay.

15 Filed JAN 8 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest, (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia due to perforation of the Uterus through a Criminal Abortion. Homicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jany. 7, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 8 1924
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

TION is very important: See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D 82487

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 315 S. Duncan St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances. Morawski

(a) Residence No. 315 S. Duncan St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 20 1910

7-AGE.	If LESS than 1 day,
13 yrs. mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Morawski

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country).

12-MAIDEN NAME OF MOTHER, Catherine. Paczkowski

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country).

14- (Informant) Mr. John. Morawski
(Address) 315 S. Duncan St.

15- Filed 1924 Robt. F. Harrison, Registrar.

Burial Permit Clerk

NO 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 7, 1924, that I last saw h— alive on Jan 7, 1924, and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Wahrhaftig M. D.

19- (Address) 14 So Rose

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary DATE OF BURIAL. Jan 10 1924

20-UNDERTAKER, John A Weber ADDRESS 1803 Bank St

Instructions to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82488

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 226 S Washington St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kurek

(a) Residence No. 226 S. Washington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 11 1900

7-AGE. 23 yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Oprator

(b) General nature of industry, business, or establishment in which employed (or employer) Erlangers

(c) Name of employer Shirt Manf.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. John. Kurek

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER. Frances . Stasiak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant). Mrs Frances . Kurek

(Address) 226 S. Washington St.

15- Robert P. Harrison,

Filed ..... 192.....

Registrar.

NS -1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1923 to Jan 8 24

that I last saw h[illegible]alive on Jan 24

and that death occurred, on the date stated above, at 1020 AM

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chas. O. Weed M. D

1/8/24 (Address) 408 St Paul Pl Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL. Jan 12 19 24

20-UNDERTAKER. John M Weber — ADDRESS 803 Bank St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82489

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 508 S. Patterson Park ave., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casimier . Rusin

(a) Residence No. 508 S. Patterson Park ave., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sep. 1853

7-AGE. 70 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

11-(Informant): Mr Bernadzikowski

(Address): 508 S. Patterson Park Ave

15-Filed JAN 5 - 1924 19?? Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to Jan 7 19 24

that I last saw h.. alive on Jan 6. 19 24

and that death occurred, on the date stated above, at 745 P.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

Signed: Jan 8 19 24 Hugh Parker M. D.

(Address) 1500 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Jan 10 19 24

20-UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Pierce ST. 19 WARD)

REGISTERED NO. 82490

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Stanley

(a) RESIDENCE. NO. 628 Pierce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Stanley

6 DATE OF BIRTH (month, day, and year): Oct. 30 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): out

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Jos. Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mary Matthews 628 Pierce

15 Filed JAN 8 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to Jan 6, 1924

that I last saw h.. alive on Jan 6, 1924

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Apoplexy. (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Kirk, M. D.

Jan 9-24 (Address) North Ave & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan. 9, 1924

20 UNDERTAKER: Jas H Dennis

ADDRESS: 1800 Pennsylvania Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be proTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82491

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 82491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 N.Parrish ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Young.

(a) RESIDENCE NO. 1139 N.Parrish ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1882

7 AGE 41	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		XX	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Young (Address) 1139 N.Parrish St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

N8 -1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1924.

17

I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1924, to Jan. 7, 1924; that I last saw her alive on Jan. 6, 1924, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Of Stomach

Metastasis to Liver and Peritoneum

Lymph Glands

(duration) X yrs. 5 mos. X ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage from eroded Gastric Artery (duration) X yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Carcinomata palpable

(Signed) Charles E. Clark M.D., M. D.

, 19 (Address) 1306 W. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.F. Auburn Cemetery — DATE OF BURIAL Jan 9. 1924

20 UNDERTAKER Jas H Dennis — ADDRESS 1309 Pennsylvania Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM

Cor.—1-12-23—M&T—100 Bks.

D 82492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82492

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Miemczyk

(a) RESIDENCE No 2213 Eastern Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) OCT 30/21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John J. Miemczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Kurek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: John J. Miemczyk
(Address): 2213 Eastren Ave

15 Filed ..... 192 ..... Registrar
Robert P. Harrison,
Burial Permit Clerk.

JAN 8 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental-Burns over rt. side head thorax & arm. Fell into wash boiler of hot water. 1/8/24

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Toller, M. D.
(Coroner.)

Jan 8/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 10 1924
20 UNDERTAKER	**ADDRESS**
John H Weber	1803 Bank St

IN CASES OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... state ... PHYSICIANS should ... TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82493

CERTIFICATE OF DEATH.

129 D 82493

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N. Bradford St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriett Ann Butler

(Residence in Baltimore: No. 520 N. Bradford St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ... unknown ..... (Month) (Day) (Year)

7-AGE, given age 57 apparent 25 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Susan Crowner

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Hattie Davis Broadnax

(Address)..... 520 N. Bradford St

15- Filed JAN 9 - 1924 ROBERT R. KRAUTER, Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan ..... 6 ..., 1924 ... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... (last date unknown 1922) (accessed between these dates) ..... to ..... July 6 ..... 1924, that I saw her alive on ..... June 5 ..... 1924, and that death occurred, on the date stated above, at 10 30 A.m.

The CAUSE OF DEATH* was as follows:

..... Chronic Interstitial Nephritis .....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) ..... R J Young ..... M. D.

1/7, 1924 (Address) 1424 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery — DATE OF BURIAL, Jan 9, 1924

20-UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

D 82494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 D 82494

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 N. Spring ST., 9 WARD)

2-FULL NAME George A. Welch

(a) RESIDENCE NO 1527 N. Spring ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Margaret Welch

6 DATE OF BIRTH (month, day, and year) March 31/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophia Brannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Margaret Welch
(Address) 1527 N. Spring St

15 Date JAN 3 - 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilitation

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Mocius, M. D.
(Coroner.)

Jan 8/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 1 10 1924

20 UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82495

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 N. Luzerne ST., 7 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lang

(a) RESIDENCE No. 803 N. Luzerne ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert A. Lang

6 DATE OF BIRTH (month, day, and year) May 29/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Neubert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Eva B. Seberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mr. Albert Lang

(Address) 803 N. Luzerne

15 Filed JAN 9 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1922 to Jan 7, 1924

that I last saw her alive on Jan 7, 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym + Symptoms

(Signed) Walter Graf, M. D.

(Address) 541 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 11 1924

20 UNDERTAKER Jos J. Merriadon — ADDRESS 156 N. Luzerne

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ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis.

Study 6231

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82496

90 D 82496

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3304 Fairmount ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin a. Nelson

(a) RESIDENCE. NO. 3304 Fairmount ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C. Nelson

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Representative

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Benjamin T. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Margaret Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Jennie C. Nelson
(Address) 3304 Fairview Ave.

15 Filed JAN 9 1924 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1923, to Jan 8 1924,

that I last saw h.. alive on Jan 7 1924,

and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis, Angina Pectoris

19 days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Hardening of arteries
(duration) 1 day yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) Carlton M Cook, M. D.

Jan 8, 1924 (Address) 2219 St Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 10 1924
20 UNDERTAKER Ralph B. Cook	ADDRESS 1003 N Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82497 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1732 W. Lexington St. St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Abell

(a) Residence No. 1732 W. Lexington St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 3 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas L. Abell

6-DATE OF BIRTH (month, day and year) Sept. 8, 1858

7-AGE. 65 yrs. 3 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, George L. Renner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Justine Wagner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Thomas L. Abell

(Address) 1732 W. Lexington St.

15- Filed JAN 9 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1- 1923 to Jan 7 1924

that I last saw he alive on Jan 7- 1924

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martin A Shook M. D.

1-7- 1924 (Address) 806 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Jan 9 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N Eutaw St

All items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. Every item of information should be given.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82498

CERTIFICATE OF DEATH.

1644

D 82498

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2033 N Washington St. 8 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary D. Eckhardt.

(a) Residence No... 2033 N Washington St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of J. C. Eckhardt.

6-DATE OF BIRTH (month, day and year) May 11. 1835

7-AGE, 88 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Gunther

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Annie Vonbortner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Wm C Eckhardt

(Address) 2033 N Washington St

15- Filed JAN 9 1924 192... ROBERT R. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 26, 1923, to Jan 7, 1924, that I last saw her alive on Jan 7, 1924, and that death occurred, to the date stated above, at 5.20 P.m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Age

(Duration) several yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Cramer, M. D.

1-8, 1924 (Address) 1706 E Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel. DATE OF BURIAL, Jan 9, 1924

20-UNDERTAKER. A Neumann ADDRESS 32 S Bond.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificate. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D 82499 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82499

CERTIFICATE OF DEATH. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Fairfield St., 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Cunningham

(a) RESIDENCE NO. 706 N Fairfield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Cunningham

6 DATE OF BIRTH (month, day, and year) unk 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Henry Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Maggie Ramsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant (Address) James Cunningham 706 N Fairfield St.

15 Filed JAN 9 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Jany 7th, 1924.

that I last saw her alive on Jany 6th, 1924

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pneum

(duration) yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Ex

(Signed) A. Hirschfelder M. D.

19 (Address) 1340 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch Jan 10 1923

DATE OF BURIAL

20 UNDERTAKER John H. Toadvine

ADDRESS 142 W. Hill St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82500

CERTIFICATE OF DEATH.

31

D 82500

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 N. Carey ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Irving Sisco

(Residence in Baltimore: No. 1525 N. Carey St.; 37 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1886 (Year)

7-AGE. 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ofc

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Susan

(Address) 1525 N. Carey St.

15- Filed JAN 9 - 1924, 191... ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 5 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1923, to Jan 5 1924, that I saw him alive on Jan 5 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Diabetes Mellitus

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Hughes M. D.

1/10/24, 191... (Address) 637 Hughes St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL, Jan. 9., 1924

20-UNDERTAKER John H Soden

ADDRESS 142 Mitchell St

NOTE.—Items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

b 82501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

b 82501

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1503 Prestmann ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Lewis & Katie Hackney

(Residence in Baltimore: No. 1503 Prestmann St St.; yrs., mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Infant

6-DATE OF BIRTH. Dec. (Month) 25 (Day), 1923 (Year)

7-AGE. ....yrs. ....mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). none

9-BIRTHPLACE. (State or Country). City

PARENTS.

10-NAME OF FATHER. Louis Hackney

11-BIRTHPLACE OF FATHER (State or Country). St Louis

12-MAIDEN NAME OF MOTHER. Katie Tenish

13-BIRTHPLACE OF MOTHER (State or Country). St Louis

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Hackney

(Address) 1503 Prestmann St

15-

Filed JAN 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. (Month) 8 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dr. J. J. Hennessy M. D. (Coroner.)

Jan. 8 1924 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Iron	Jan 10 1924
20-UNDERTAKER	ADDRESS
Clarence E. Wright	1364 Carey St

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Thos. Early.

D 82502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82502

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 W. Lombard ST., 18 WARD)

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos Early

(a) RESIDENCE No. 1205 W Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos Early

6 DATE OF BIRTH (month, day, and year): Sept 14 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Patern Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Thos Early

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Rachal Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs Thos Early

(Address): 1205 W Lombard

15 Filed ....., 19.... ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 8, 1924, that I last saw h alive on Jan 8, 1924 and that death occurred, on the date stated above, at 7 H m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

Jan 9 1924 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters

DATE OF BURIAL: Jan 11 1924

20 UNDERTAKER: John J Fields

ADDRESS: 1310 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82503

CERTIFICATE OF DEATH.

129 D 82503

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Roland Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Amelia Ingram

(a) RESIDENCE No. 210 Roland Ave ST., 27 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? 76 yrs. 2 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Ingram

6 DATE OF BIRTH (month, day, and year) Oct. 30-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER ✓ James C. Matthai

11 BIRTHPLACE OF FATHER (city or town) Bavarra
(State or country) Germany

12 MAIDEN NAME OF MOTHER Teresa Jackins

13 BIRTHPLACE OF MOTHER (city or town) Alsace
(State or country) France.

14 Informant Mr James E. Ingram Jr.
(Address) Roland Park, Baltimore

15 Filed JAN 9 1924, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1924, to Jan. 7, 1924, that I last saw h[illegible] alive on Jan. 7, 1924 and that death occurred, on the date stated above, at 8-10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia with
Acute Pulmonary Edema

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted —
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Gibson Porter, M. D.

1/8, 1924 (Address) 22 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Jan. 9 1924

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM E. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82504

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Linden ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Robinson

(a) RESIDENCE No. 2044 Linden ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed.

6a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of James H. Robinson

6 DATE OF BIRTH (month, day, and year) Mar 23/53

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home odd

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER Wm. Blackford

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Jersey

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant Lillian M Green

(Address) 2044 Linden

15 Filed JAN 9 - 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 5, 1924, that I last saw her alive on Jan 5, 1924, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

don't know about

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma one hour

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knight, M. D.

1/6, 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Jan 9 1924

20 UNDERTAKER: H M Routson — ADDRESS 2238 N Monroe

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82505

CERTIFICATE OF DEATH.

74 D 82505

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 211 N Lanvale ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Montesey Watson Iglehart

(a) RESIDENCE NO. 211 N Lanvale ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of Dr James D Iglehart

6 DATE OF BIRTH (month, day, and year) Sept 29th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	77	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Col W^m H Watson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Taylor

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Maryland

14 Informant Dr James D Iglehart
(Address) 211 N Lanvale St

15 Filed JAN 9 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 4, 1924, to Jany 8, 1924,

that I last saw h^r alive on Jany 8, 1924,

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Coma)

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) Nephritis

(duration) Unknown yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Charles O'Donovan, M. D.

Jan 9, 1924 (Address) 5^a E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 11 1924
20 UNDERTAKER	ADDRESS
Henry H Jenkins Son	Cathedral & Mt Vernon Pl

Burial Permit Issued

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfuiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especiaiiy in industrial empioyments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the iatter statement; it should be used oniy when needed. As exampies: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfuiiy employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of iiiness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for mailgnant neopiasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated uuless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Coliapse," "Coma," "Convuisions," "Debility" ("Congenitai," "Senlie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Aiways quaiify all diseases resuiting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgicai operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skuii, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—1-10-21—M&T—1500 Blks.

D 82506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-001

D 82506

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Kunzelmann KUNZELMANN Rappeturg

(a) RESIDENCE NO. 63 Powell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 7th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore. (State or country) Maryland

PARENTS

10 NAME OF FATHER John Kunzelmann

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Carl Kolleck

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant (Address) John Kunzelmann 63 Powell Ave. Rappahannock

15 Filed JAN 9 - 1924 ROBERT R. KRAUTH Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 8 — 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-7-, 1924. to 1-8-, 1924.

that I last saw h alive on Jan 8th, 1924,

and that death occurred, on the date stated above, at 8:40 A m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) A C Manning, M. D.

1-8-, 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 10, 1924
20 UNDERTAKER	ADDRESS
Fred'k Loose and Sons	Fullerton

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Annie E. Simpkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82507

CERTIFICATE OF DEATH.

90 D 82507

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 E. Biddle ST., 11 WARD)

2-FULL NAME Annie E. Simpkins

(a) RESIDENCE No. 117 W. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Simpkins

6 DATE OF BIRTH (month, day, and year): Jan. 20 1845

7 AGE — Years: 78 Months: 11 Days: 19 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Camden, N. J.

PARENTS

10 NAME OF FATHER: Samuel Fultz

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Caroline Fultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): London New Jersey

14 Informant: Samuel Simpkins (Address) 117 W. Biddle St.

15 Filed JAN 9 1924 19.... ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 8th 24

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 1923, to Jan 8th, 1924, that I last saw h[illegible] alive on Jan 7th, 1924, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis M. D.

(Address) 924 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 10 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82508 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH.

D 82508

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1203 N. Caroline St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Seigle

(a) Residence No. 1203 N. Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M | 4-COLOR OR RACE, W | 5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ida Seigle

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 45 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis
(Address) 1439 E. Baltimore St

15- Filed JAN 9 - 1924 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 8/24

17- I HEREBY CERTIFY, That I attended deceased from ——, 1923, to Jan 7, 1924, that I last saw him alive on Jan 7, 1924, and that death occurred, on the date stated above, at 4 P m. The CAUSE OF DEATH* was as follows:

Carcinoma of Cardiac end of stomach (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Physical

(Signed) A. L. Hornstein M. D.

1/9, 1924 (Address) 733 Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pikesville Nursery Cem. DATE OF BURIAL, Jan 9, 1923

20-UNDERTAKER, Jack Lewis ADDRESS 1439 E. Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec.—5-19-13—M. & T.—500 Bks.

D 82509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Oakfield ave ST.; 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Rick

(Residence in Baltimore: No. same 3101 Oakfield ave St.; 25 yrs mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept (Month) 26 (Day), 1866 (Year)

7-AGE, 57 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance man
(b) General nature of industry, business, or establishment in which employed (or employer): Ins Co

9-BIRTHPLACE, (State or Country) Rock Hall Md

PARENTS.

10-NAME OF FATHER, Thomas J Rick

11-BIRTHPLACE OF FATHER (State or Country), Carolina So Md

12-MAIDEN NAME OF MOTHER Catherine Stevens

13-BIRTHPLACE OF MOTHER (State or Country) Kent Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary M Rick

(Address) 3101 Oakfield Ave

15-

Filed JAN 3 1924 ROBERT A. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 8 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1923 to January 8th 1924 that I saw h[er] alive on January 7th 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Interculoce

(Duration) 1 yr. 6 mos.

CONTRIBUTORY (Secondary) Stomach Debility

(Duration) 1 yr. 3 mos. ds.

(Signed) H. Stanley Gorsuch M. D.

1-9-, 1924 (Address) 1900 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Jan 11, 1924

20-UNDERTAKER George J Smith

ADDRESS 1532 Hollins st

INFORMATION.—Exactness of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Casler.

D 82510 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82510

CERTIFICATE OF DEATH. 4 177 ✓

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 704 W Lamston St St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie L. Casler.

(Residence in Baltimore: No. 704 W Lamston St St.; yrs. 30 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mrd

6-DATE OF BIRTH, Dec (Month) 4 (Day) 1885 (Year)

7-AGE, 38 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Hosp

9-BIRTHPLACE, (State or Country), Vermont

PARENTS.

10-NAME OF FATHER, Ed Norton

11-BIRTHPLACE OF FATHER, (State or Country), Vt

12-MAIDEN NAME OF MOTHER, Bell Boynton

13-BIRTHPLACE OF MOTHER, (State or Country), Vt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bell Laydon

(Address) 704 W Ly

15-

Filed JAN 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 6 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or Inquiry.)... thereon and from the evidence obtained by said ....Inquest, autopsy or Inquiry.)... find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Don't Know (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. H. Lemmel M. D. (Coroner.)

1-8 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Jan 9 1924

20-UNDERTAKER, Harry N. Leitz & Co ADDRESS 523 W Lombard St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82511 90 D 82511

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 326 W. Camden St

CITY OF BALTIMORE: (No. 326 W. Camden ST. 77 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhardt Zwitzers

(a) RESIDENCE. NO. 326 W. Camden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Marie Zwitzers

6 DATE OF BIRTH (month, day, and year) Dec 11, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 000
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Zwitzers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie Zwitzers
(Address) 326 W Camden St

15 Filed JAN 9 - 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 7, 1924, that I last saw h.... alive on Jan 7, 1924, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

, 19 (Address) 602 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Trinity Cemetery Jan 10 1924

20 UNDERTAKER — ADDRESS

Harry H. Witzke 1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Cor.—1-12-23—M&T—100 Bks.

D 82512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001
74 D 82512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Lane & 2nd (Highland Town) ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Albert Robert Geade

(a) RESIDENCE NO. 3815 Foster ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth L. Geade

6 DATE OF BIRTH (month, day, and year) Nov. 24th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore Copper Smelting & Rolling Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth L. Geade
(Address) 3815 Foster Ave

15 Filed JAN 9 1924 ROBERT P. KRAUSER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

Jan 7th, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Mitchell's Lot	Jany 9 1924
20 UNDERTAKER	ADDRESS
Capt Kenna	444 Light

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be given as nearly as possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state exactly what it is. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Norman Lazarus

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 82513

CERTIFICATE OF DEATH.

X32 D 82513

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Norman Lazarus

(a) RESIDENCE No. Beckley W. Va. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922 - May 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Isaac Lazarus

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sylvia Benn

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Record.
(Address)

15 Filed ..... 19 .....

JAN 9 1924 HUBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/2/24, 19 ..... to 1/9/24, 19 .....

that I last saw h... alive on 1/8/24, 19 .....

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) H. W. Keller, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington D.C. DATE OF BURIAL Jan 10 19 24

20 UNDERTAKER Jack Levin ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82514

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 D 82514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Univ Hospital B WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Hughes James A. Hughes

(a) RESIDENCE NO. 1415 Eastern Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 5 mos. 22 ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James H. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella G. Dalsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Hilda Mitchell

(Address) 530 W. 72 St New York N.Y.

15 Filed JAN 9 - 1924 Registrar

ROBERT E. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/24 19

17

I HEREBY CERTIFY, That I attended deceased from 1/3/24, 19..., to 1/6/24, 19...,

that I last saw him alive on 1/6/24, 19...,

and that death occurred, on the date stated above, at 12.20 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1415 Eastern Ave.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm Rodman, M. D.

1/9/1924 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Jan. 10 1924

20 UNDERTAKER Henry Hovell Son — ADDRESS 1301 E Eager St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82515

10-001 ✓ D 82515

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Curley ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bridget Bridget Lamb

(Residence in Baltimore: No. 215 N. Curley St.; 50 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Unknown (Month) (Day), 185[illegible] (Year)

7-AGE, 66 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 110

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Lamb

(Address) 215 N. Curley St

15. JAN 9 - 1924

Filed....., 191.....

ROBERT E. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June. (Month) 7 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June. 4, 1924 to June. 7, 1924, that I saw h[illegible] alive on June. 6, 1924, and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Eugene L. Cassard M. D.

June 7, 1924, 191... (Address) Glen Hills

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cathedral Cemetery	1.1.0....., 1924
20-UNDERTAKER	ADDRESS
Chas. B. Crane & Son	1180 W. Royal ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82516

CERTIFICATE OF DEATH.

D 82516

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 627 First ST., 25 WARD)

2-FULL NAME Jennie Benton

(a) RESIDENCE No. 627 First st Westport ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 8 1924

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: C. E. Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wilmington N.C.

12 MAIDEN NAME OF MOTHER: Jennie Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant (Address): Mrs C. E. Benton 627 First st Westport

15 Filed JAN 9 - 1924 19 ROBERT R. KRAUTER, Burial Permit Officer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-8- 1924, to 1-8- 1924, that I last saw her alive on 1-8- 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Old

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Sigfund Drucker, M. D.

....., 19 (Address) 1 Key Highway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cross Cem Co

DATE OF BURIAL: Jan 9 1924

20 UNDERTAKER: James Dignan & Son

ADDRESS: 1000 S. Pac St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 82517

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 Jonkins ST., 11 WARD)

2-FULL NAME Mary Underwood

(a) RESIDENCE NO. 1031 Jonkins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colord	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	[illegible]	[illegible]	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) O'D

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Filip Underwood

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ether Simth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Robert Jenkins
(Address) 1129 N. Calhoun St.

15 Filed ..., 19 ... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1, 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov ..., 1923, to Jan 7th, 1924, that I last saw h[illegible] alive on Jan 2d, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) L. A. Gehant, M. D.

19, 1924 (Address) 241 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. F. Auburn Cemetery — DATE OF BURIAL: Jan. 10, 1924

20 UNDERTAKER: James H. Dennis — ADDRESS: 1303 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 9 1924

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 82518

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82518

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Gilmor ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie Bell Minor.

(a) RESIDENCE. NO. 1227 Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Joseph Minor.

6 DATE OF BIRTH (month, day, and year) Jan 6. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Spotsylvania Virginia

PARENTS

10 NAME OF FATHER Robert Stanford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spotsylvania Va.

12 MAIDEN NAME OF MOTHER Dollie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spotsylvania Va.

14 Informant Martha Epps. (Address) 1340 N Fulton Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1923, to Jan 7, 1924, that I last saw h.. alive on Jan. 6, 1924, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Phlebitis? Filroid.
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? 1227 Gilmor

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) William F. Wright, M. D.

(Address) 1209 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan. 10, 1924
20 UNDERTAKER	ADDRESS
James H. Dennis	1303 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82519

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2206 Boston St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Miller

(a) Residence No. 2206 Boston St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 1857

7-AGE: 66 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Annadel Sand & Gravel Co

9-BIRTHPLACE (city or town) (State or Country): Camden New Jersey

PARENTS.
10-NAME OF FATHER: Not Known
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12-MAIDEN NAME OF MOTHER: Not Known
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-(Informant): Charles Bangert
(Address): 2206 Boston St

15-
Filed ... Robert F. Harrison, Registrar.
JAN 9 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 7, 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 19 23 to Jan 7 19 24
that I last saw him alive on Dec 6 19 24
and that death occurred, on the date stated above, at 5 10 P.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Edward Leon

What test confirmed diagnosis?

1/8 19 24 (Signed) 413 N Washington M. D
(Address) 413 N Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Jan 10 19 24
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very ... instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82520

CERTIFICATE OF DEATH.

X 49

D 82520

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine O'Hara

(a) RESIDENCE NO. Texas Md. ST., WARD Texas Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 5 mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John O'Hara.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record. (Address)

15 Filed JAN 9 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8/24 19

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1923, to 1/8/24, 19..., that I last saw h... alive on 1/8/24, 19..., and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Head of Pancreas.
Cholecystitis

7 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 12/11/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operative

(Signed) K. W. Hadley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cemetery, Texas	1/11 19 24
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1221 East Preston St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Dennis

(a) Residence No. 1221 East Preston St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Dennis

6-DATE OF BIRTH (month, day and year) March 22, 1861

7-AGE. 62 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Thomas Pierson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaretta----------

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) William Dennis

(Address) 1221 East Preston St.

15- Filed JAN 9 - 1924 19.. Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 3 19.3 to Jan 7, 1924

that I last saw h[illegible] alive on Jan 6 19.24

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

.....

.....

.....

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Palpation

(Signed) Benj. D. Hayden M. D.

1/9, 1924 (Address) 1616 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	1/10/24 19....
20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H P. Co.—1000 Bks.

D 82522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82522

CERTIFICATE OF DEATH.

127

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W Lexington ST.: Vol. Hospital. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine Archie

(a) RESIDENCE. NO. 129 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Paul Archie 893

6 DATE OF BIRTH (month, day, and year) [redacted]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	30			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Meisel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Paul Archie
(Address) 129 N. Washington St.

15 Filed ....., 19 .....
Registrar

JAN 9 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1923, to Jan 7, 1924

that I last saw h er alive on Jan 7, 1924

and that death occurred, on the date stated above, at 6:80 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 3 yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B.P. & urine

(Signed) C. Smink, M. D.

, 19 (Address) 3706 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 10 1924
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: Be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82523

CERTIFICATE OF DEATH.

179 D 82523

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital (St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Fanny B. Harding

(a) RESIDENCE NO. 3219 Belmont Ave ST., Howard Park,

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Hopkins Harding

6 DATE OF BIRTH (month, day, and year): Jan 26, 1858

7 AGE: Years 66 Months 11 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Mississippi

PARENTS

10 NAME OF FATHER: Aherall Ball (a)

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER: Florida Limonds (b)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C.

14 Informant: Mrs. Ethel E. Adams

(Address) 3219 Belmont Ave Howard Park

15 Filed JAN 9 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1924. to Jan. 8, 1924.

that I last saw her alive on Jan. 8, 1924;

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Burns (fire)

Very extensive, 1st & second degree. (over)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Surgical Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? Yes Date of Jan 7-1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. E. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hardings Va — DATE OF BURIAL: Jan 9 1924

20 UNDERTAKER: John Mitchell — ADDRESS: 1201 W Fayette St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

O. K.
J. T. Hennessy M.D
Coroner N.W. Dist.
1/9/24.
Gown caught fire from Gas Stove

Reg 3858

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—2000 Bks.

D 82524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82524

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home Chemnt Hill Ave ST.; 7 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta Silverberg Jackson

(a) RESIDENCE. No. St. Elizabeths Home ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: negress

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8/23

7 AGE — Years: — Months: 4 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crownsville State Asylum Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Ida Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address)

15 Filed JAN 9 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8 1924

17 I HEREBY CERTIFY, That I attended deceased from December, 1923, to January 7, 1923, that I last saw h[illegible] alive on January 7, 1923, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Jan 8, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: NS HOPKINS HOSPITAL

DATE OF BURIAL .....

20 UNDERTAKER .....

ADDRESS .....

JAN 9 - 1924

Commissioner Health.

KODAK

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Jackson)

D 82525

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 82525

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 Dolphin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Jackson

(a) RESIDENCE. No. 532 Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	col	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Jackson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer — , ,

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant annie Myrick

(Address) 532 Dolphin St

15 Filed JAN 9 - 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to June 7, 1924 that I last saw her alive on June 7, 1924 and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Organic insufficiency

(duration) , yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) R. H. Johnson, M. D.

, 19 (Address) 211-E-23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mont- Auburn Cemetery	Jan 10 1924
20 UNDERTAKER John H Owens	ADDRESS 532 Dolphin St

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Vincent Inf Asylum 14 WARD) 185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Celestia McConnell

(a) RESIDENCE. No. 140 Division St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) [illegible] 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Thomas McConnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) St Vincent Inf Asylum 140 Division St

15 Filed JAN 9 - 1924

16 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1924, to Jan 8th 1924, that I last saw her alive on Jan 7th 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation following Pneumonia (bronchial)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Fracture of hip (over) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Hayward, M. D.

1/9, 1924 (Address) 225 W Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan 10 1924
20 UNDERTAKER	ADDRESS
Martin Tuskey Sons	1827 W North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The deceased, a Sister of Charity, was 82 yrs of age. While crossing her room on Jan. 4 she collapsed & flew striking thigh and fracturing it at neck.

C. H. Hayward

Spec.—1-10-21—M&T—1500 Blks.

D 82527

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101-001 D 82527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Charles Gaither

(a) RESIDENCE No. West Friendship Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? 33 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	—	1	

8 OCCUPATION OF DEECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Mary land

PARENTS

10 NAME OF FATHER Evans Gaither

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary land

12 MAIDEN NAME OF MOTHER Matilda Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Gilbert Gaither
(Address) Derby Md.

15 Filed JAN 9 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8 19 24

17

I HEREBY CERTIFY, That I attended deceased from December 26, 19 23, to January 8, 19 24,

that I last saw him alive on January 8, 19 24,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess (Rt Lung)

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) Jas Hunter Wilkerson, M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co. Brown's Chapel Cem. — DATE OF BURIAL Jan. 11 19 24

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82528

CERTIFICATE OF DEATH.

74081 146.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 W Cross, ST., 21 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Miller.

(a) RESIDENCE NO. 1221 W Cross ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 25 yrs.

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robt. Miller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Robt. Miller
(Address) 1221 W Cross St.

15 Filed JAN 6 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1924, to Jany 7, 1924 that I last saw him alive on Jan 7, 1924, and that death occurred, on the date stated above, at 4 35 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Dorsey, M. D.

, 19 (Address) 422 North Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 10, 1924
20 UNDERTAKER John F. Cowan & Son Est'd J. F. Cowan	ADDRESS 400 Holliday St

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 82529

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 413 N. Glover ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Anna Kimmerle

(a) RESIDENCE NO 413 N.Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (late) Ferdinand Kimmerle

6 DATE OF BIRTH (month, day, and year) Apr 19/1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Leabert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Chas J. Kimmerle
(Address) 537 N Kenwood Ave

15 Filed JAN 9 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy -(Hemorrhage)

(1st. stroke 3yrs ago)

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. J. Wallis, M. D. (Coroner.)

Jan 9/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 1/10 192

20 UNDERTAKER Lilly & Geiler ADDRESS 403 N. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be stated AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Conlee

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82530

CERTIFICATE OF DEATH.

38 B 82530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Maryland Ave ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Conlee

(a) RESIDENCE NO. 1207 Maryland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Conlee

6 DATE OF BIRTH (month, day, and year) Mar 6 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co. Md.

PARENTS

10 NAME OF FATHER Rast. Conlee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cornelia Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Conlee
(Address) 1207 Marylandave

15 Filed JAN 1 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec, 6, 1923, to Jan. 8, 1924, that I last saw him alive on Jan. 8, 1924, and that death occurred, on the date stated above, at 2:40 p m.

The CAUSE OF DEATH* was as follows:

Aneurysm of abdominal Aorta

(duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J. Wheatley, M. D.

1/8/ 1924 (Address) 1230 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 19 24
20 UNDERTAKER Wm. R. C. Elliott	ADDRESS 1725 Eastlandave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lunatic

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1560 Blu.

16875?

D 82531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82531

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5

REGISTERED NO. 71-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Virginia McKethron

(a) RESIDENCE NO. 1804 Law Lt ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 26 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Jacob McKethron

6 DATE OF BIRTH (month, day, and year) ? ~~1885~~

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) ——
(c) Name of employer ——

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER William McKethron

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Eleanor

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JAN 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 8, 1924, that I last saw her alive on Jan 8, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus meningitis

(duration) 0 yrs. 0 mos 16 ds.

CONTRIBUTORY (Secondary) ——
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of (Mastoiditis 1/5/24) (1/17/24 Craniotomy)

Was there an autopsy? Yes

What test confirmed diagnosis? Spinal fluid examination

(Signed) Jerome Cohn, M. D.

, 19 (Address) Johns Hopkin Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 10 1924

20 UNDERTAKER	ADDRESS
Mrs. P. A. Elliott	925 Eastlandale

Spec—12-23-21—E.B.R.S.—400 Eks.

2220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 15 Registered No. D 82532

City of BALTIMORE: (No. 1310 Poplar Grove St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs Hensel

(a) Residence No. 1310 Poplar Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Hensel

6-DATE OF BIRTH (month, day and year) July 15-1856

7-AGE. 67 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Post Office

9-BIRTHPLACE (city or town) (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER. John Hensel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Mary Ross

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) John F. Hensel

(Address) 1310 Poplar Grove

15 JAN 10 1924 16 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1924, to Jan 8 — 1924, that I last saw him alive on Jan — 7 — 1924, and that death occurred, on the date stated above, at 10.9 a.m.

The CAUSE OF DEATH* was as follows:

Carbuncle on back with general infection

(over)

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Cole M. D.

1/9, 1924 (Address) 720 N Gamson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Westlin Cemetery | DATE OF BURIAL Jan 10th 1924

20-UNDERTAKER, F B Heppert | ADDRESS 2236 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms): *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

(Septicaemia) (no Diabetes)
Seen for and with
Dr. W. S. Niblett, who
is now confined to
his home with Phonyp
A. T. Cole

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md. Gen'l. Hospital. 1 29 D 82533 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Christian Huhn

(a) RESIDENCE NO. 810 S. Belnard Ave. WARD 1

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Agnes Huhn

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman 06

(b) General nature of industry, business, or establishment in which employed (or employer) Packing Plant.

(c) Name of employer O. P. Roberts.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christian Huhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Susan ——.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Anthony Huhn (Address) 810 S. Belnard Ave.

15 Filed JAN 7 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 7, 1924

that I last saw him alive on Jan 7, 1924,

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis (Uraemic Coma)

(duration) 3+ yrs. ✓ mos — ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

(duration) 3+ yrs. ✓ mos. — ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory & Clinical.

(Signed) Dr. A. Lampstein, M. D.

, 19 (Address) 1 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Jan 11 1924

20 UNDERTAKER Stephen J. Fialkowski ADDRESS 1000 S. Hanover Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82534

CERTIFICATE OF DEATH.

X129

D 82534

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 812 S. 2nd ST., 26 WARD)

2-FULL NAME Clarance A Taylor

(a) RESIDENCE NO. 812 S. 2nd (Usual place of abode) ST., 26 WARD Cleveland Ohio (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. — ds. How long in U. S., if of foreign birth? — yrs. 3 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) — 015

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Geo. A Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Jane Boughton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Bert Taylor (Address) 812 S. 2nd St

15 Filed ....., 19 .... ROBERT R. KRAUTER, Registrar Burial Permit Clerk

JAN 6 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from December 7, 1923, to Jan. 7, 1924.

that I last saw him alive on Jan 7, 1924

and that death occurred, on the date stated above, at 9.45 p m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromsbus, M. D.

1-6, 1924 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Jan 10 1924
20 UNDERTAKER	ADDRESS
Stephen J Stalkowski	1002 Eastern Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 82535

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 Fulton Ave ST., 19 WARD)

2-FULL NAME Margaret Mary Miller

(a) RESIDENCE NO. 213 Fulton Ave ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frank George Miller

6 DATE OF BIRTH (month, day, and year) Nov 27 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~Under~~	30	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ernest H. Meister

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Gaeiner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Frank G. Miller
(Address) 213 S Fulton Ave

15 Filed JAN 10 1924 19 ROSLEY R. KNAUER Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923 to Jan 8, 1924.

that I last saw h.. alive on Jan 8, 1924.

and that death occurred, on the date stated above, at 9 13 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis, Chronic

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) James F. Hutchinson, M. D.

1/9. 1924 (Address) 1724 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 12 1924

20 UNDERTAKER Wm. Wesch & Sons — ADDRESS 1737 W Pratt

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No abdominal condition

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Frahley

(a) RESIDENCE No. 2826 Winchester St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of H. E. Frahley

6 DATE OF BIRTH (month, day, and year) Sept 10 1901

7 AGE: Years 22 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm R. Keith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emily J Keith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Howard E Frahley 2826 Winchester St

15 JAN 01924 19 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1924, to 1/9, 1924, that I last saw her alive on 1/8, 1924, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Postapsestive Ileus

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1/3/24

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) J. B Futterhouse M. D.

1924 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md — DATE OF BURIAL: Jan 12 1924

20 UNDERTAKER: CHENOWETH & SON, — ADDRESS: 3917 CHESTNUT AVE.

#33394

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Appendicitis

Spec.—1-12-23—M&T—500 Blks.

D 82537

HEALTH DEPARTMENT—CITY OF BALTIMORE

T105 D 82537

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2909 Overland Av ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Eckert

(a) RESIDENCE NO. 2909 Overland Av ST., 27 WARD Syracuse N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 21 ds. How long in U. S., if of foreign birth? 54 yrs. 6 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Leonard Eckert

6 DATE OF BIRTH (month, day, and year) July - 2 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~24~~	54	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) New York City
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Charles Flandreee

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Ackerman

13 BIRTHPLACE OF MOTHER (city or town) Pleasantville
(State or country) New York

14 Informant Mrs Louis Evans - (daughter)
(Address) 2909 Overland Av.

15 Filed JAN 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1924, to Jan. 8, 1924, that I last saw h alive on Jan 8, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cardiac ~~Dilatation~~
Dilatation during
asthmatic attack

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) ....yrs. ....mos. few ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 (Address) 4706 - 4706 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Jan 10 1924

20 UNDERTAKER [illegible] & MOWEN COMPANY — ADDRESS 103 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Not Tubercular

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

82538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 82538

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Oxford Road ST., 27 WARD)

2-FULL NAME Eleanor J Burnside

(a) RESIDENCE NO. 108 N. Oxford Road ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 17th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	79	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER James Burnside

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Georgia L. Dickerson

(Address) 165 Oxford Road

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

JAN 10 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1924

17

I HEREBY CERTIFY, That I attended deceased from June 4th, 1924, to Jan. 8, 1924, that I last saw her alive on Jan 7, 1924, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema due to

acute Cardiac dilatation

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 50 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Bulkeuse, M. D.

1-8, 1924 (Address) Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 11th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Spec.—8-24-14—M. & T.—2000 Blks.

D 82539

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 82539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 W. Saratoga ST.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Dalores Gurklis

(Residence in Baltimore: No. 1821 W. Saratoga St.; ....yrs.,.... mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) —

6-DATE OF BIRTH, Dec 15, 1923
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Paul Gurklis

11-BIRTHPLACE OF FATHER (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER Anna Bubnis

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr J A McDonough

(Address) 638 Wash Blvd

15- JAN 10 1924 Filed..... 19..... ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 4 1924, to Jany 8 1924, that I saw her alive on Jany 8 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration).....yrs.....mos. 2 ds.

(Signed) J A McDonough M. D.

Jan 9, 1924 (Address) 638 Wash Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1821 W Saratoga St

19-PLACE OF BURIAL OR REMOVAL, Mt Vincent Cem Lot 69 Space 3 Sec 10 | DATE OF BURIAL, Jan 10, 1924

20-UNDERTAKER Chas B Kyle & Sons | ADDRESS 600 E Pratt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82540

CERTIFICATE OF DEATH

38 D 82540

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 N. Bond ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Foster.

(a) RESIDENCE NO. 232 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Divoiced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife

6 DATE OF BIRTH (month, day, and year): Dec 25, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Jennie Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary L. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Raymond Foster (Address) 2312 N Bond St

15 Filed JAN 1 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-8- 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-1- , 1923, to 1-8- , 1924, that I last saw h alive on 1-7- , 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Cargill, M. D.

1-9- 1924 (Address) 611 N. Carolin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Jan 13 1924

10 UNDERTAKER: Robert R. Williams — ADDRESS: 1515 Mc Elderry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82541

CERTIFICATE OF DEATH.

D 82541

REGISTERED NO. 4 129

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 700 N. Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stanmore

(a) RESIDENCE. No. 700 N. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Stanmore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..., min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Household duties

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lancaster Pa.

PARENTS

10 NAME OF FATHER David Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Va

12 MAIDEN NAME OF MOTHER Mary Gretton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Va.

14 Informant (Address) Robert Lee Lancaster Va.

15 Filed JAN 10 1924, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1923, to 1-7, 1924, that I last saw her alive on 1-5, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia + Gastritis
(Pleuring 3 wks)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) W. A. Farmer, M. D.

1/7, 1924 (Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Co Va.	Jan 11 1924

20 UNDERTAKER ADDRESS

Robert F. Williams 1515 Mt. Elderry st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial
Not Tubercular
" Luetic

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82542

CERTIFICATE OF DEATH.

74-0010

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 E. Preston ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret. A. Kerr

(a) RESIDENCE NO. 1421 E Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Henry Kerr

6 DATE OF BIRTH (month, day, and year) March 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Ireland

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Miss. Graglia

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mrs Elizabeth Leitch

(Address) 1421 E Preston St

15 Filed JAN 1 0 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 3, 1927, to Jany 9, 1927, that I last saw h live on Jany 9, 1927, and that death occurred, on the date stated above, at 4 15 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. Thomas, M. D.

Jan. 10 1927 (Address) 1254 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Dawn Cemetery — DATE OF BURIAL Jan. 12 1924

20 UNDERTAKER Henry Storck Son — ADDRESS 1301 E Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Blks.

D 82543

HEALTH DEPARTMENT—CITY OF BALTIMORE

107-D 82543

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 441 Augusta Ave ST., 20 WARD)

2-FULL NAME Mary E. Bohannon

(a) RESIDENCE No. 441 Augusta Ave ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. Herbert A Bohannon

6 DATE OF BIRTH (month, day, and year) May 21 1868

7 AGE: Years 55 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Vann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Capt H A Bohannon 441 Augusta Ave

15 Filed ..... 19 ..... Registrar

JAN 1 0 1924

ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 19 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to January 8, 1924, that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung

(duration) 15 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 1913

Was there an autopsy? .....

What test confirmed diagnosis? Operation

(Signed) H. Leary, Jr. M. D.

1/9, 19 24 (Address) 1169 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lowden Park

DATE OF BURIAL 1-11 1924

20 UNDERTAKER Robert Brooks & Son.

ADDRESS Hollins & Carrollton Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not T. B. or Traumatic

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82544

CERTIFICATE OF DEATH.

Registered No. 159-002

D 82544

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Pratt St. ST., 7-5 WARD)

2-FULL NAME Unk mamed Baby Benton

(a) RESIDENCE No. 627 Pratt St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-8 24

7 AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Clarence Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Doctor Stephen Flam

(Address) 727 Washington Blvd

15 Filed JAN 6 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-8-, 1924, to 1-10-, 1924

that I last saw h[illegible] alive on 1-10-, 1924

and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Marasmus Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Flam, M. D.

, 19 (Address) 727 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: 1-10 1924

20 UNDERTAKER: James Digman & Son

ADDRESS: [illegible] Pratt St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82545

CERTIFICATE OF DEATH.

101-006 82545

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Maryland ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johnson Goodison

(a) RESIDENCE. No. 1805 Maryland St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Mary Johnson
(Address) 1805 Maryland Ave

15 Filed ..., 19 ...

Registrar

JAN 7 1924

ROBERT E. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 7, 1924, that I last saw h... alive on Jan 7, 1924 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Gardner Johnson M. D.

1924 (Address) 1134 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cem.	Jan. 10th 1924
20 UNDERTAKER Joseph A Farrell	ADDRESS 2317 Division St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82546

CERTIFICATE OF DEATH.

12 9 V D 82546

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 N. Collington Ave ST., 8 WARD)

2-FULL NAME Martin Boecking

(a) RESIDENCE NO. 1838 N Collington Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 36 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Late Elizabeth Boecking

6 DATE OF BIRTH (month, day, and year) Mar 14/40

7 AGE — Years: 83 — Months: 9 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hair Factory

(b) General nature of industry, business, or establishment in which employed (or employer): Do

(c) Name of employer: Wilkins & Co

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Boecking

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Marie Timbel

(Address) 838 N. Collington Ave

15 Filed JAN 10 1924 ROBERT F. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1923, to Jan 8, 1924, that I last saw him alive on Jan 7, 1924, and that death occurred, on the date stated above, at 4 43 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) A Herzog M D, M. D.

1/9, 1924 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon PK — DATE OF BURIAL: 1/10 1924

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82547

CERTIFICATE OF DEATH.

90 D 82547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 N Calvert ST., 10 WARD)

2-FULL NAME Dr Basil L Gildersleeve

(a) RESIDENCE No. 1002 N Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 23 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	92	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Professor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Charlestown Mass.

PARENTS

10 NAME OF FATHER Ben Gildersleeve

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER E Lamean

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Y

14 Informant: Mrs R Coltson Gildersleeve

(Address): New York

15 Filed JAN 1 01924 Registrar: ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany 8th 1924, to Jany 9th 1924,

that I last saw him alive on January 9 1924,

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(With Bronchial Diffusion)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F. Lockwood M. D.

1/10/, 1924 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Jan 12 1924

20 UNDERTAKER: A W Jenkins Sons Co

ADDRESS: Orchard nr Gold

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82548

CERTIFICATE OF DEATH.

74-001 D 82548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E Chase St ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harrison Maben Clark

(a) RESIDENCE No. 11 E Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single, Married,~~ Widowed, or ~~Divorced,~~ (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER John Maben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Scamble

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Mr Clark

(Address) 11 E Chase

15 Filed JAN 10 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Jan 9, 1924

that I last saw h[illegible] alive on Jan 9, 1924,

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julian Friedrunes, M. D.

Jan 10, 1924 (Address) 1013 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Jan 11 1924

20 UNDERTAKER Henry Jenkins Sons Co — ADDRESS Orchard & Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21 M&T 1500 Blks.

D 82549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 82549

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 Roslyn Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond E. Dessford

(a) RESIDENCE No. 2801 Roslyn Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Etta Dessford

6 DATE OF BIRTH (month, day, and year) Jan 12, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	52	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice Pres

(b) General nature of industry, business, or establishment in which employed (or employer) Hillyard Rubber Co

(c) Name of employer Washington D.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER James Wm Dessford

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Susanna Kerr

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Mary E. Dessford

(Address) 2801 Roslyn Ave

15 Filed JAN 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17

I HEREBY CERTIFY, That I attended deceased from January 3, 1923, to January 9, 1924.

That I last saw him alive on January 9, 1924.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis → Nephritis → Uraemia

(duration) 6+ yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No B.P. 240-260 Albuminuria & Hyaline casts. Blood urea 180 Haematuria. Albumin

What test confirmed diagnosis? Albumin. Blood urea 180 Haematuria. Albumin

(Signed) Chas C. Guard, M. D.

, 19 (Address) 1701 Madison Ave. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Jan. 12, 24

20 UNDERTAKER Wm Fitchett Sons ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 82550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001

D 82550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Eden ST., 3 WARD)

2-FULL NAME Chava Solomonovitz

(a) RESIDENCE NO. 218 S. Eden st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grutman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Leffler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sholom Solomonovitz

(Address) 218 S. Eden st

15 JAN 1 0 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th 1924 to Jan 8 1924.

that I last saw h[illegible] alive on Jan 8 1924

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? Symptoms

(Signed) Maurice Medical, M. D.

1924 (Address) 2328 Med av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	1/10 1923
20 UNDERTAKER	ADDRESS
S. Levinson & Bro	E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32551

CERTIFICATE OF DEATH.

D 32551

1-PLACE OF DEATH Christ's Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Abel

(a) RESIDENCE NO. 1701 N. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If ~~Married, Widowed, or Divorced~~ HUSBAND of ~~or WIFE of~~ Adolf Abel

6 DATE OF BIRTH (month, day, and year) Sept 24 1869

7 AGE Years 54 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Greiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adolf Abel (Address) 1701 N Durham

15 Filed Jan 11 '24 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9 1924

17 I HEREBY CERTIFY, That I attended deceased from January 2 1924 to January 9, 1924 that I last saw her alive on January 9 1924 and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Gangrene Limb & Foot (duration) 1 yrs. 4 mos. 17 ds.

18 Where was disease contracted if not at place of death? 1701 Durham St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. H. Kennard, M. D.

1-9. 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date Cemetery

DATE OF BURIAL Jan 12 1924

20 UNDERTAKER Robt Johnson Sr

ADDRESS 1424 N. Bway

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82552 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Watson

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country).

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JAN 10 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 21, 1923 to January 8, 1924

that I last saw him alive on January 8, 1924

and that death occurred, on the date stated above, at 1:55 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis;

Myocardial Insufficiency

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Claude S. Dean M. D

1-8-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Osborn Cem	1-10-, 1923
20-UNDERTAKER Dunbar Estate	ADDRESS 916 E Pr Av

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82553

CERTIFICATE OF DEATH.

118 D 82553

1-PLACE OF DEATH

City of BALTIMORE: (No. 1048 Penna ave. 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Rados.

(a) Residence No. 1048 Penna ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M | 4-COLOR OR RACE, W | 5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12-12-23

7-AGE, yrs. mos. 27 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 000

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto-ley (State or Country),

PARENTS.

10-NAME OF FATHER Stephen Rados.

11-BIRTHPLACE OF FATHER (city or town) Greece (State or Country),

12-MAIDEN NAME OF MOTHER Evatoka Bellos

13-BIRTHPLACE OF MOTHER (city or town) Greece (State or Country),

14-

(Informant) Stephen Rados

(Address) 1048 Penna-a

15-

Filed 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-9-24

17- I HEREBY CERTIFY, That I attended deceased from 1-7- 1924 to 1-9 1924, that I last saw him alive on 1-9- 1924, and that death occurred, on the date stated above, at 8 A. m. The CAUSE OF DEATH* was as follows:

Intussusception.

(Intestinal)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. D. Spencer M. D

1-10 1924 (Address) 1604 Linden ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cem	1-10 1924
20-UNDERTAKER.	ADDRESS
Bird Ferson	Penna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82554

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 Madison Ave ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Friedman

(a) RESIDENCE. No. 1904 Madison Ave ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos ..... ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shirt Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Abraham Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hannah Lubofski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Morton Roscover

(Address): 1904 Madison Ave

15 Filed JAN 4 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8th 1924

17

I HEREBY CERTIFY, That I attended, deceased from Jan 4th, 19 24 to Jan 8th, 19 24

that I last saw h m alive on Jan 8th, 19 24

and that death occurred, on the date stated above, at 11 50P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation Eclamp

Lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph Friedman, M. D.

(Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cemetery	Jan 11 1924
20 UNDERTAKER	ADDRESS
J. Ahrens & Son	611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82555

CERTIFICATE OF DEATH.

129 D 82555

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rollins Carr

(a) RESIDENCE No. 1044 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucille Carr

6 DATE OF BIRTH (month, day, and year) 1898 Sept 1

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	25	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Brick Layer

(c) Name of employer Va. Oil

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Virginia Carr

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hospital Record (Address)

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar

JAN 6 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/24

17 I HEREBY CERTIFY, That I attended deceased from 1/4/24, 19..., to 1/9/24, 19..., that I last saw h— alive on 1/9/24, 19..., and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lexington Va — DATE OF BURIAL Jan 10 1924

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 82556

1-PLACE OF DEATH

City of BALTIMORE: (No. 3400 Gwynns Falls Pky St., 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Moorehead

(a) Residence No. 3400 Gwynns Falls Pky St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Blanche E Moorehead

6-DATE OF BIRTH (month, day and year) Feb 14 1864

7-AGE. 59 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer). Superior Court

(c) Name of employer. Baltimore Md

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. William H Moorehead

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Elizabeth Quincy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Marie E Phillips

(Address) 3500 Fairview Ave.

15- JAN 1 0 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 9. 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1923 to Jan 9 1924 that I last saw h/m alive on Jan 9 1924 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Signs & symptoms

(Signed) Wallace & Gill M. D

Jan 10 1924 (Address) 2406 Garrison ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Jan 11 1924

20-UNDERTAKER. John A Mitchell

ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 82557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82557

CERTIFICATE OF DEATH.

REGISTERED NO. C 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 W. Lexington ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara A. Bachmann

(Residence in Baltimore: No. 1316 W. Lexington St. 56 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August (Month) 29 (Day), 1868 (Year)

7-AGE, 55 yrs. 4 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Louis Wouthseth

11-BIRTHPLACE OF FATHER (State or Country) France

12-MAIDEN NAME OF MOTHER Louisa A. Stumme

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Bachmann

(Address) 1316 W. Lexington St.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 8th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4th 1924, to Jan 8 1924, that I saw h[er] alive on Jan 4 1924, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Leonard E. Blaich M. D.

Jan 9, 1924 (Address) 2231 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Jan 11, 1924

20-UNDERTAKER John O. Mitchell

ADDRESS 201 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

ROBERT R. KRAUTER, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82558

D 82558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 Brighton ST. 16 WARD)

2-FULL NAME John H Baylis

(a) RESIDENCE No. 3201 Brighton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Elizabeth Jaeger Baylis

6 DATE OF BIRTH (month, day, and year): Sept 16 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stock Monitor

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Bartlett Hayward Co

9 BIRTHPLACE (city or town) (State or country): Washington

PARENTS

10 NAME OF FATHER: Jas R. Baylis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Eliz A.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs Baylis [redacted]

15 Filed JAN 10 1924 19 ROBERT M. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923, to Jan 7, 1924, that I last saw h[illegible] alive on Jan 7, 1924, and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

1 Month or More

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Liver + Kidneys

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas E Parker, M. D.

, 19 (Address) 3123 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Jan 11 1924

20 UNDERTAKER: James Hynes — ADDRESS: 1324 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 82559

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Vincents Infant asyl

CITY OF BALTIMORE: (No. 1401 Division St., ST., 14 WARD)

2-FULL NAME Charles Edward Smith

(a) RESIDENCE No. 1401 Division St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 1-24

7 AGE: Years —; Months —; Days 7; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

PARENTS

9 BIRTHPLACE (city or town) (State or country): St. Vincents Infant asyl 1401 Division St Balt. Md.

10 NAME OF FATHER: Edward Neyko

11 BIRTHPLACE OF FATHER (city or town) (State or country): Yorkemir Yorkemir.

12 MAIDEN NAME OF MOTHER: Mary Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Westminster Md

14 Informant: Mrs. Smith
(Address): Westminster Md

15 Filed JAN 10 1924 ROBERT R. KOUNTZ Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1924, to Jan. 8th, 1924, that I last saw him alive on Jan. 8th, 1924, and that death occurred, on the date stated above, at 12.59 P. m.

The CAUSE OF DEATH* was as follows:

Insanition

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity 28 wks.

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis H. Douglas, M. D.

1-8, 1924 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem — DATE OF BURIAL: Jan 10 1924

20 UNDERTAKER: Martin Tuckey Sons — ADDRESS: 1424 W North Ave

Cor.—1-12-23—M&T—100 Bks.

Dr Dennessy, 2811 Edmondson Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82560

CERTIFICATE OF DEATH.

90 D 82560

1-PLACE OF DEATH 513 North Fulton Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Charles W Ridgaway

(a) RESIDENCE NO. 513 North Fulton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Ridgaway

6 DATE OF BIRTH (month, day, and year) Sept 15, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coach Trimmer
(b) General nature of industry, business, or establishment in which employed (or employer) 207
(c) Name of employer Baltimore Buggy Co

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Samuel S Ridgaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Hathaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annie M Ridgaway
(Address) 513 No Fulton Ave

15 Filed ....., 192 ..... Registrar

Burial Permit Clerk.

JAN 16 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic heart disease

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Jan. 16, 1924 (Address) 2811 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Anne, Annapolis, Md	Jan 12 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E Biddle

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82561

CERTIFICATE OF DEATH.

D 82561

31

REGISTERED NO. 15

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Klank

(a) RESIDENCE No. 2829 W. North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia Klank

6 DATE OF BIRTH (month, day, and year) Jan 9, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engraver

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Klank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Walters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

16 Informant Hospital Records

(Address) M. T. H.

17 Filed JAN 01924, 19 Robert F. Harrison, Registrar

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1924, to Jan. 9, 1924,

that I last saw him alive on Jan. 9, 1924,

and that death occurred, on the date stated above, at 4.55, p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) W. A. Lally, M. D.

1-9-24, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Jan 12 1924

20 UNDERTAKER Wm. Leo[illegible] & Son

ADDRESS E. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Favorite)

D 82562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82562

CERTIFICATE OF DEATH.

11-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3627 Hedeny St.; 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Favorite

(a) RESIDENCE. NO. 3627 Hedeny St. 13 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos Arthur

6 DATE OF BIRTH (month, day, and year) July 4, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Camden (State or country)

PARENTS

10 NAME OF FATHER John Phillips

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Julia Mccann

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mattie L. Favorite

(Address) 3627 Hedeny St

15 Filed JAN 10 1924 19.....

Robert P. Matson

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1923, to Jan 9, 1924

that I last saw h[illegible]tive on Jan 9 1924

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Lagrippe (Dysenza)

(duration) yrs. mos. 15 ds.

CONTRIBUTGIN (Secondary) Jaundice

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) C. F. Corkran M. D.

1-10 1924 (Address) 3702 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover, Pa	Jan 11 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82563

D 82563

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 St John's Court ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Butler

(a) RESIDENCE NO 815 ST John's Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Butler

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Alice Butler
(Address) 815 ST John's Court

15 Filed JAN 8 1924, 192 Robert P. Harrison, Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilitation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Chr. Myocarditis (duration) yrs. mos. ds.

(Signed) J. S. H. Cocas, M. D.
(Coroner.)

Jan 6/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL JAN 10 1924

20 UNDERTAKER Commissioner Health. — ADDRESS JAN 10 1924

Wm. M. WOOCALL

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 82564

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/16 82564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Lexington St. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Commodore

(a) RESIDENCE NO. 1116 E. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	60	yrs		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address) JOHNS

15 Filed JAN 10 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 192 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Probably Pulmonic tuberculosis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Nausea (duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner)

Jan 4, 192 4 (Address) 1058 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: JAN 10 1924

20 UNDERTAKER — ADDRESS

Commissioner Health, per. Wm. E. WOODALL

JAN 10 1924

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82565

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Jefferson ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. G. Wilkison

(a) RESIDENCE NO. 2227 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan T. Wilkison

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	79	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Bank

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Wilkison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Elliott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Ada Apsley

(Address) 2227 Jefferson St.

15 Filed JAN 1 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 19 24, to Jan 8, 19 24, that I last saw him alive on Jan 8, 19 24, and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardia Dilatation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? physical

(Signed) Geo. Keller M. D.

(Address) 1937 Yough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan. 11, 1924
20 UNDERTAKER	**ADDRESS**
Wm. C. Black,	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82566

CERTIFICATE OF DEATH.

90 D 82566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3127 Guilford ave. ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie B. Wagner

(a) RESIDENCE No. 3127 Guilford ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E. Wagner

6 DATE OF BIRTH (month, day, and year): Aug. 10-1858

7 AGE — Years: 65 — Months: 4 — Days: 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Nathaniel B. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Senora Landerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Miss Mattie Wagner

(Address) 3127 Guilford Ave.

15 Filed JAN 10 1924, 19 ..... Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June, 1915, to January 8, 1924, that I last saw h[illegible] alive on January 8, 1924, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Osteo. Malacia.

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Dill, M. D.

, 19 (Address) Wylie ave & Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Jan. 11 1924

20 UNDERTAKER: Wm E. Black ADDRESS: 927 N. Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82567

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 82567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Williams

(a) RESIDENCE No. 1075 S. Carlton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Chas Williams

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Rena Dahl

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Hospital Record (Address)

15 Filed JAN 1 0 1924, 19 ..... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1924.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923. to Jan 9, 1924.

that I last saw him alive on Jan 9, 1924

and that death occurred, on the date stated above, at 8.54 p. m.

The CAUSE OF DEATH* was as follows:

Lues, congenital

Cerebro spinal

(duration) 0 yrs. 5 mos. 19 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Jay Martin, M. D.

Jan 9, 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co — DATE OF BURIAL 1-11 1924

20 UNDERTAKER Robert Brooks & Son — ADDRESS Catherine & Carrollton Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82568

CERTIFICATE OF DEATH.

101-09

D 82568

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 N. Calhoun ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank T. Marshall

(a) RESIDENCE No. 1336 N. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9-1901

7 AGE 22 Years 9 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Jenny Hawkins

(Address) 1336 N. Calhoun St

15 Filed , 19 Robert J. Norrigan Registrar

JAN 10 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 9, 1924.

that I last saw h~~im~~ alive on Jan 9, 1924.

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Generally Opposed

& valid (duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Ludd Hall, M. D.

, 19 (Address) 1826 E. 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemty — DATE OF BURIAL 1/11/24

20 UNDERTAKER George I. A. Gibson — ADDRESS 1733 Druid Hill Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82569

CERTIFICATE OF DEATH.

159-002 D 82569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 S. Sharp St. ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sayles. (C)

(a) RESIDENCE NO 1111 S. Sharp St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January, 1, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
----------	----------	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Arthur Sayles. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Pricilla Rogers. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Pricilla Sayles. (C) mother.
(Address) 1111 S. Sharp St.

15 Filed JAN 1 01924 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.
Jany, 10, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health. — ADDRESS .....

Per. Wm. H. WOODALL.

JAN 10 1924

Robert P. Harrison

JOHNS HOPKINS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 82570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82570

181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 636 W Lombard St., St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Burke.

(Residence in Baltimore: No. 636 W. Lombard St., 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Sept (Month) 12 (Day) 1875 (Year)

7-AGE: 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plumber
(b) General nature of industry, business, or establishment in which employed (or employer): 059

9-BIRTHPLACE, (State or Country): W. Va.

PARENTS.

10-NAME OF FATHER: Patrick Burke

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Nancy Hamrick

13-BIRTHPLACE OF MOTHER, (State or Country): W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Burke

(Address) 1432 Penrose Av.

15- Filed JAN 10 1924, 192.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day) 1924 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, ~~autopsy or~~ Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of illuminating Gas

9 Hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M R Grinnell M. D.

(Coroner.)

1-10 1924 (Address) 1717 W Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Parkersburg W Va. DATE OF BURIAL: Jan 10th 1924

20-UNDERTAKER: A. Jones ADDRESS: 111 S. Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 82571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 D 82571

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1715 Edmondson Ave ST.) 19 (WARD)

2-FULL NAME Eleanor Virginia Probest

(a) RESIDENCE. No 1715 Edmondson Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of George E. Probest

6 DATE OF BIRTH (month, day, and year) May 26, 1836

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Beard

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Reese

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George E. Probest
(Address) 32[illegible] Edgehill Road Baltimore

15 Filed JAN 9 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan- 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec- 26, 1923, to Jan- 9, 1924, that I last saw h[illegible] alive on Jan- 9, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

(duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Glen S. Bishop, M. D.

, 19 (Address) 1500 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
George I Smith	Jan 12 1924
20 UNDERTAKER	ADDRESS
Loudon Park Cem	Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

(Irvin M. F. Hellman)

D 82572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82572

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1213 Glyndon ave St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin M F Hellman

(Residence in Baltimore: No. 1213 Glyndon ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Aug 15 (Month) (Day) 1922 (Year)

7-AGE, 1 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto Md.

PARENTS.

10-NAME OF FATHER, Herman C. Hellman

11-BIRTHPLACE OF FATHER, (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER, Ruth E. Cavanaugh

13-BIRTHPLACE OF MOTHER, (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman C. Hellman

(Address) 1213 Glyndon Ave

15-

Filed JAN 9 1924, 192.. Robert P. HARRISON, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Hug death on the day stated above.

The CAUSE OF DEATH* ~~was as follows:~~

Gastro-Enteritis

(Duration) .....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) James H. Fenlon M. D. (Coroner.)

Jan 9th 1924 (Address) 201 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet DATE OF BURIAL, Jan 11, 1924

20-UNDERTAKER, The Mrs. John W. Leufer & Son ADDRESS 1801 E. Fayette

No. 8—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Ensor St. ST., 5 WARD)

REGISTERED NO. 29 D 82573

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Bersterman.

(a) RESIDENCE No 406 Ensor St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June, 9, 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	43	6	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Franz Bersterman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Katherine Remmel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna E. Cowman, (sister)
(Address) 1704 Rutland Ave.

15 Filed JAN 7 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January, 8, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nebhritis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)

Jany. 10, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 1-11 192 4

20 UNDERTAKER Geo. J. Ruth — ADDRESS 1755 Hanford Av

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D 82574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward) 22

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Bernice Hammet

(Residence in Baltimore: No. 4401 Reedy Ave Rovan st.; 3 yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, Sept 9. 1920
(Month) (Day) (Year)

7-AGE, 3 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS:

10-NAME OF FATHER, Raymond Hammet

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Georgie Henley

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Hammet

(Address) 4401 Reedy Ave

15- Robert P. Harrison,

Filed 19 Burial Permit Clerk. Registrar.

JAN 10 1924

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over almost entire body-
accidental- Clothing caught fire
playing with matches

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. J. Potter M. D.
(Coroner.)

Jan 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan. 10, 1924

20-UNDERTAKER, Wm. Jno. Kuehn & Bro. ADDRESS, 1600 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82575

CERTIFICATE OF DEATH.

12 ✓ D 82575

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 Whitridge Ave 12 WARD)

2-FULL NAME Ralph Adolphus Poole

(a) RESIDENCE NO. 435 Whitridge Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Poole

6 DATE OF BIRTH (month, day, and year) July 7, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	79	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett & Hayward

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Howard Co
(State or country) Md

PARENTS

10 NAME OF FATHER Owen Poole

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Leach

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Md.

14 Informant Miss May Poole
(Address) 435 Whitridge Ave.

15 Filed JAN 10 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st 1923, to Jan 9th 1924 that I last saw h— alive on Jan 9th 1924; and that death occurred, on the date stated above, at 11.35 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis (interstitial)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Retention of urine

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests.

(Signed) S. Sirota, M. D.

1-10-1924 (Address) 2102 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	1-12-1924
20 UNDERTAKER Wm J. McKewen Sons	ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 82576

31

B 82576

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2123 McHenry ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Eber.

(a) RESIDENCE No. 2120 McHenry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 0+2

(b) General nature of industry, business, or establishment in which employed (or employer) Boy Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Eber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Eber

(Address) 4727 Leet Ave

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 9, 1924, that I last saw him alive on Jan 9, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Lymphadenitis

X Gruppen

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness (duration) yrs. mos. 3, ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. D. Driscoll M.D.

, 19 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Jan 12 1924

20 UNDERTAKER Wm. Miss & Sons ADDRESS 1737 N Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Folding C. Bradley.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82577

CERTIFICATE OF DEATH.

D 82577

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Orchard ST., 17 WARD)

2-FULL NAME Folding O. Bradley

(a) RESIDENCE NO. 1010 Orchard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	80	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of Industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Lofton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucy B. Grace
(Address) 1010 Orchard St

15 Filed ....., 19 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1923 to Jan 9th 1924

that I last saw h... alive on Jan 9th 1924

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) His age & custom

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. [illegible] M. D.

192 (Address) 92 W Mad

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct — DATE OF BURIAL Jan 11 1923

20 UNDERTAKER J. W. Brown & Son — ADDRESS 708 W. Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 11 1924

Spec.—1-10-21—M&T—1500 Bks.

George J. Holland

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82578

91-002

D 82578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 587 Orchard ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Holland

(a) RESIDENCE NO. 587 Orchard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Holland

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md. Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary J. Holland

(Address) 587 Orchard St.

15 Filed JAN 1 1924 16 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1923 to Jan 8th, 1924 that I last saw h alive on Jan 1st, 1924 and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Influenza 7 old age.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observed

(Signed) A. Lee Ellis, M. D.

(Address) 1220 Mondawmin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Jan 11 1924

20 UNDERTAKER Mrs. R. C. Elliott ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82579 D 82579

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Home

CITY OF BALTIMORE: No. 1112 N. Mount ST., 7 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. White

(a) RESIDENCE NO. 626 N. Bethel ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia White

6 DATE OF BIRTH (month, day, and year) Aug 5, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) City Water Dept.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Chas. A. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Harman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Julia White
(Address) 626 N. Bethel St.

15 Filed JAN 11 1924 19 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 9, 1924.
that I last saw him alive on Jan. 9, 1924
and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

① Irremovable Stricture of Posterior Urethra

② Retrogression of Urine into Kidneys

10 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia - 36 hours

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Jan. 5, 1924

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) A. A. Spoonger, M. D.
President
(Address) Colonial Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedony Cemetery — DATE OF BURIAL Jan 13 1924

20 UNDERTAKER Mrs R. A. Elliott — ADDRESS 1720 Ashland.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus Infection

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82580

CERTIFICATE OF DEATH.

113 ✓ D 82580

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 712 Ensor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph Boswell

(a) Residence No. 712 Ensor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 13-1922

7-AGE. 1 yrs. 10 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank Boswell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Lottie Fawcus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Frank Boswell

(Address) 712 Ensor

JAN 11 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Jan 9, 1924 that I last saw h[illegible] alive on Jan 9, 1924 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John [illegible] M. D.

Jan 10, 1924 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Jan 11, 1924

20-UNDERTAKER, Mrs Chas G. Bailey — ADDRESS 14 Jefferson St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82581

CERTIFICATE OF DEATH.

46 D 82581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2828 Clifton Ave ST., 15 WARD)

2-FULL NAME Elizabeth A. Willis

(a) RESIDENCE NO. 2828 Clifton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Husband of E A. Willis

6 DATE OF BIRTH (month, day, and year) Apr. 21 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	72	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER J.S. Ragland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Chick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant (Address) F.D. Willis 2828 Clifton ave

15 Filed JAN 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from October 3rd 1923 to January 11th 1924.

that I last saw h. alive on January 10th 1924

and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Yes Date of Oct. 16-23

Was there an autopsy? No

What test confirmed diagnosis? Examination Operation

(Signed) P E Lilly, M. D.

, 19 (Address) 800 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va DATE OF BURIAL Jan 13 24

20 UNDERTAKER H S Marshall ADDRESS 353 Fallsway

Spec.—1-10-21—M&T—1500 Bks.

Minnis

D 82582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 82582

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 153 Vine ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Minnis

(a) RESIDENCE NO. 153 Vine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isbell Minnis

6 DATE OF BIRTH (month, day, and year) Unknown, 1858

7 AGE Years 66 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer With. Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Isbell Minnis

(Address) 153 Vine St

15 Filed JAN 1 1924 ROBERT A. KRAUSER Register

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 8, 1924, that I last saw h alive on Jan 8, 1924 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Monroe, M. D.

Jan 9, 1924 (Address) 934 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loth Cluburn Cem

DATE OF BURIAL 1/11 1924

UNDERTAKER Samuel Hendley

ADDRESS 718 N Bdle

Cor.—1-12-23—M&T—100 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82583

CERTIFICATE OF DEATH.

38 D 82583

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 N. Paca St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lonnie Williams

(a) RESIDENCE NO. 645 N. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia Williams

6 DATE OF BIRTH (month, day, and year) about 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver, v3
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Henry Moran

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Georgia Williams
(Address) 2613 N. Mulberry St.

JAN 1 1924 Filed ..... 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Jan. 8, 1924 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL 1/11 192

20 UNDERTAKER Samuel Hensley | ADDRESS 1100 Bdle St.

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificate.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

DAK

Spec.—1-10-21 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82584

CERTIFICATE OF DEATH.

X 11

D 82584

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lamar Engel

(a) RESIDENCE NO. 2405 N. 7th St Phil. Pa ST., WARD Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Engel

6 DATE OF BIRTH (month, day, and year) July 5, 1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
29 yrs	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (37)

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo H. Ruhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie Emmert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dr. J. B. Hall

(Address) Washington Boulevard

JAN 1 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to Jan. 4 1924.

that I last saw h.. alive on " 9 1924,

and that death occurred, on the date stated above, at 11 28 a m.

The CAUSE OF DEATH* was as follows:

Lung Abscess

abt

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/14/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H O Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan. 7 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	1101 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

A. J. Spendiccetti

Spec.—1-10-21—M&T—1500 Bks.

D 82585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-001 D 82585

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 W Barre ST., 22 WARD)

2-FULL NAME Baby Brown

(a) RESIDENCE NO. 606 W Barre ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			6	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ezekiah Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Trow

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mother
(Address) .....

JAN 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 9, 1924, that I last saw her alive on Jan 9, 1924, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thomas Reese, M. D.

1/10, 1924 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 11 1923
20 UNDERTAKER John H. Toadvine	ADDRESS 143 Uniel St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 ✓

D 82586

CERTIFICATE OF DEATH.

D 82586

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 E. Smallwood St.; 15 Ward)

2-FULL NAME Grace S. Ward

(a) RESIDENCE. No. 2011 E. Smallwood St.; Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Garner Ward

6 DATE OF BIRTH (month, day, and year) July 15- 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. A Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Alice G. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Garner Ward

(Address) 214 Wadsworth ave

15 Filed ....., 19.....

JAN 11 1924

ROBERT M. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8— 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 8, 1924, that I last saw h[illegible] alive on Jan 8, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] Hammond Lynch, M. D.

Jan 9, 1924 (Address) 835 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Jan 11 1924
20 UNDERTAKER	ADDRESS
H M Routson	2238 N. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82587 B 1685 3

101-001 ✓ D 82587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Margaret Greger.

(a) RESIDENCE No. 705 Fourth St. South Hamilton Town, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years X | Months 8 | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): "
(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: John Greger
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto
12 MAIDEN NAME OF MOTHER: Margaret Barnhart
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 JAN 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 09, 1924 to Jan 9, 1924.
that I last saw her alive on Jan 9, 1924,
and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary)
Empyema (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes. Date of Dec. 18, 1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Post mortem Examination

(Signed) Casper Peterson, M. D.
, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Jan. 11 1924

20 UNDERTAKER: Lilly & Zeile ADDRESS: 403 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 82588

D 82588

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 N. Bond ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Haensler Jr.

(a) RESIDENCE No. 1807 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Amelia Haensler

6 DATE OF BIRTH (month, day, and year) July 21/70

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Agent Lor 086

(b) General nature of industry, business, or establishment in which employed (or employer): Central Fire

(c) Name of employer: Ins. Co.

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Fredrick Haensler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Amelia Haensler

(Address): 1807 N. Bond St

15

JAN 1 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Cl. ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1924, to Jan 9th 1924,

that I last saw him alive on Jan 9th 1924

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia -

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. Gill Hall, M. D.

Jan 10. 1924 (Address) 1631 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	1/12 1924
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82589

CERTIFICATE OF DEATH.

47 D 82589

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2141 Walbrook and 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda A Carr

(a) Residence No. 2141 Walbrook st., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George Carr

6-DATE OF BIRTH (month, day and year) Aug 17 1838

7-AGE 85 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS

10-NAME OF FATHER, Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Matilda Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Geo A Carr

(Address) 2141 Walbrook ave

15- FILED JAN 1 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 1924 to Jan 10 1924, that I last saw h.. alive on Jan 9 1924, and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

about 2 hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Carcinoma about 10 months

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) G. Lotsch Ewald M. D.

1/11, 1924 (Address) 2945 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cem — DATE OF BURIAL, Jan 12 1924

20-UNDERTAKER, W M Routson — ADDRESS 2238 N Paris

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82590 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 82590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Miller. (Mueller)

(a) RESIDENCE No. 320 X Eutaw St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER J. Mack.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record (Address)

15 JAN 11 1924 ROBERT M. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/8/24

17 I HEREBY CERTIFY, That I attended deceased from 1/2/24 19.., to 1/8/24 19.., that I last saw h~~e alive~~ on 1/8/24 19.., and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Hosler, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Jan. 14 1924

20 UNDERTAKER Lilly and Zeile ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82591

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82591

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Durham ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Kountnik

(a) RESIDENCE NO. 818 N. Durham ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 33 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Kountnik

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Car Foundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Okres-tabor Cecho-slovakia

PARENTS

10 NAME OF FATHER John Kountnik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecho-slovakia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecho-slovakia

14 Informant Edward Petza

(Address) 818 N. Durham St.

JAN 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1923 to Jan. 8, 1924, that I last saw him alive on Jan. 8, 1924 and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the Lungs

..... (duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) Vincent V. Jooss, M. D.

....., 19 (Address) 845 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 12 1924
20 UNDERTAKER	**ADDRESS**
Frank Carothers	1906 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82592

CERTIFICATE OF DEATH.

31 D 82592

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N. Madeira ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Svec

(a) RESIDENCE NO. 913 N. Madeira ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Joseph Svec

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sukdol
(State or country) Czecho-slovakia

PARENTS

10 NAME OF FATHER John Tomisek

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Czecho-slovakia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Czecho-slovakia

14 Informant Joseph Svec
(Address) 913 N. Madeira St

15 JAN 11 1924 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1924, to Jan. 10, 1924, that I last saw h[er] alive on Jan. 10, 1924, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Jaska, M. D.

, 19 (Address) 845 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 12 1924
20 UNDERTAKER	ADDRESS
Grant Brockton	1906 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82593

31 D 82593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Taylor

(a) RESIDENCE NO. 1001 Pennsylvania ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.G.H.

JAN 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1923, to Jan. 8, 1924, that I last saw him alive on Jan. 8, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) L.A. Lally, M. D.

1-9-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	JAN 11 1924
20 UNDERTAKER	ADDRESS
Municipal Hospital	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82594

CERTIFICATE OF DEATH.

161-001 ✓

D 82594

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Baby Glowinski

(a) RESIDENCE NO. 211 ½ - Caston Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1924

7 AGE ✓ Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Johns Hopkins Hospital
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Mary Glowinski

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant ..... (Address) Johns Hopkins Hospital.

15 JAN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from 7 25 PM, 1924, to 8 10 PM, 1924,

that I last saw h..... alive on ....., 19 .....,

and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity - 6 months

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan M.D.

1/8. 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ..... 19 .....

20 UNDERTAKER Commissioner Health, — ADDRESS .....

Dir. Wm. R. Woodall

JAN 11 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82595

CERTIFICATE OF DEATH.

4 188-002 ✓ D 82595

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Collins.

(a) RESIDENCE No 538 E. Chestnut St. West Chester Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 55	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mercy Hospital (Address)

15 JAN 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 29, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over by car 1618 U. Ry. & E. Co.
Crushed arm, Hemorrhage. Shock.
Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jan, 10, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
Accident, Baltimore St. & Custom House

Former or usual residence Ave. Dec. 27, 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R.A.Co.	Jan 11 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D 82596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 181-001

D 82596

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 636 W. Lombard St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Lewis Cavey

(Residence in Baltimore: No. 636 W. Lombard St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
71 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tom Cutter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Rubin Cavey

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary C. Delozier

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rubin Cavey

(Address) Granite Md

15- FILED JAN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

6-11- 1924 (Address) 1711 Gaulay Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Granite Md — DATE OF BURIAL, Jan 12th 24

20-UNDERTAKER, A. Jones — ADDRESS, 111 S. Gilmor st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82597

CERTIFICATE OF DEATH.

129 D 82597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital Monument & Rutland Sts ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Fannie Krivonos (Krivonos)

(a) RESIDENCE NO. 384 Forest Street ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sam Krivonos

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 50; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lurs

(Address) 1439 E Balto St

15 JAN 11 1924 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1924

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1924, to January 11, 1924, that I last saw h[illegible] alive on January 11, 1924, and that death occurred, on the date stated above, at 5:10 A.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Hypertension and arteriosclerosis

(duration) ..... yrs. 6 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Isidor L. Jay, M. D.

Jan. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Harsing Rm DATE OF BURIAL: Jan 11 1924

20 UNDERTAKER: Jack Lurs ADDRESS: 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82598

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH 82598

CITY OF BALTIMORE. (No. St. Agnes Hospital 15 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Bowmore

(a) RESIDENCE No. 3 Cedar Road near North Road 4 ST. (Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or 5 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James A Bowmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buffalo NY

12 MAIDEN NAME OF MOTHER Adelaide D'Agnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nice France

14 Informant James A Bowmore (Address) Cedar Roads

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar. JAN 11 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 10, 1924, that I last saw h— alive on June 10, 1924, and that death occurred, on the date stated above, at 10 07 Am.

The CAUSE OF DEATH* was as follows: Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. V. Harper M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan 11 1924
20 UNDERTAKER	ADDRESS
Martin Luckey & Son	1827 Mt Pleasant

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82599

CERTIFICATE OF DEATH.

D 82599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST. WARD)

2-FULL NAME James Rowan Dolan

(a) RESIDENCE NO. (Cedar Road ST. Old Down North Road WARD the Manor)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 10-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James A Dolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buffalo NY

12 MAIDEN NAME OF MOTHER Victoria D Organ

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dist France

14 Informant James A Dolan

(Address) Cedar Road Md

15 Filed JAN 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 10, 1924, that I last saw h[illegible] alive on June 10, 1924, and that death occurred, on the date stated above, at 10 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Prematurely

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenschal — DATE OF BURIAL Jan 19 24

20 UNDERTAKER Martin Eisley & Son — ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82600

CERTIFICATE OF DEATH.

D 32600

REGISTERED NO. 15-10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Oswego Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmella Sinari

(a) RESIDENCE. No. 2509 Oswego Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28 / 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte Cnty

PARENTS

10 NAME OF FATHER Crispino Sinari

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Helen Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Butte Cnty

14 Informant Helen Kirby
(Address) 2509 Oswego Ave

15 Buried JAN 11 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 — 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1924, to Jan 10, 1924

that I last saw her alive on Jan 10, 1924

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

asphyxiation without attempt

at intubation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) James B. Kerhurst, M. D.

1-11-1924 (Address) 4012 Pine Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan 11 1924

20 UNDERTAKER Martin Kirby Son ADDRESS 1827 W North Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 82601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 E 35th ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Brougham Paca.

(a) RESIDENCE NO. 628 E. 35th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Paca

6 DATE OF BIRTH (month, day, and year) May 1st 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER Edward T. Paca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Mariana E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Hannah Paca

(Address) 628 E. 35th

Filed JAN 1 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3 1924, to Jan 9- 1924, that I last saw him alive on Jan. 9- 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Knox M. D.

1-9, 1924 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wyelills, Talbot Co. Md

DATE OF BURIAL 1/12 1924

20 UNDERTAKER John A Moran

ADDRESS 300 E. Balto St.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82602

CERTIFICATE OF DEATH.

185 D 82602

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia Covington Thompson

(a) RESIDENCE No 2205 St. Paul Street ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 62 yrs. 9 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert D. Thompson

6 DATE OF BIRTH (month, day, and year) March-30-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	9	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Rockingham N.C.

PARENTS

10 NAME OF FATHER Edwin Poctress Covington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Louise Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Mr. Warren A/ Stewart (Son-in-law)
(Address) 2205 St. Paul St.

15 JAN 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-10-1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull at base

Accidental-Fell down stairs-
Jan 10/24 (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. T. Collins, M. D.
(Coroner.)

Jan 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs. ....mos. ....ds. In the State 8 yrs. ? mos. ? ds.

Where was disease contracted, if not at place of death? 2205 St Paul St

Former or usual residence 2205 St Paul St

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rockingham N.C.	Jan-11-1924

20 UNDERTAKER MOWEN COMPANY
J. T. WOODEN, Successor

ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 32603

CERTIFICATE OF DEATH.

90 D 32603

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1623 N. Appleton St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME Instead of street and number.)

2-FULL NAME Louis Barris

(a) Residence No. 1623 N. Appleton st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Barris

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Balto St.

15- JAN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 5, 1919 to Jan. 10, 1924

that I last saw him alive on Jan. 10, 1924

and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Hans Strauss M. D.

1/11, 1924 (Address) 122 W. Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem. DATE OF BURIAL. Jan 11 1924

20-UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82604

CERTIFICATE OF DEATH.

1-001 D 82604

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 540 Moore ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Gilmore

(a) RESIDENCE NO. 540 Moore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1910

7 AGE: Years 14; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lancaster Co. Va

PARENTS

10 NAME OF FATHER: Abr Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lancaster Co. Va

12 MAIDEN NAME OF MOTHER: Edda Gilmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lancaster Co. Va

14 Informant: Marie Jackson

(Address) 535 Moore St

JAN 11 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 19 24

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1923, to Jan 10, 19 24, that I last saw h[illegible] alive on Jan 9, 19 24, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City of Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) J. Snee Rae, M. D.

1-10 19 24 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL 1-12 19 24

20 UNDERTAKER: Druid Ecobon

ADDRESS 916 Pa ave

Spec.--1-10-21 --- 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~16885~~ D 82605

CERTIFICATE OF DEATH.

23 D 82605

1 PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE; (NO. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathleen Keaton

(a) RESIDENCE NO. 1202 Mc Culloh St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Keaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Martha Medgin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Records

(Address) JOHNS HOPKINS HOSP.

15 JAN 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924 to Jan 9, 1924

that I last saw her alive on Jan 9, 1924

and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Encephalitis, acute epidemic

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Lumbar puncture

(Signed) H. N. Wood M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-12-24
20 UNDERTAKER Dunn Earlam	ADDRESS 616 Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

82606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 32606

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 Fremont St.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Hammond

(a) RESIDENCE. No. 642 Fremont St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	1	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Jos Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sarah Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Jos Hammond
(Address) 642 Fremont St

15 Filed ....., 19 ....

JAN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 10, 1924, that I last saw her alive on Jan 9, 1924, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. P. Smyth, M. D.

1-10 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn, Cem	1-12 1924
20 UNDERTAKER	ADDRESS 916 Pa ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82607

CERTIFICATE OF DEATH.

13 D 82607

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 122 Patapsco St. Westport Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Oline Carrie O'Connell

(a) Residence No. 122 Patapsco St. Westport Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) Dec 22-1923

7-AGE. ....yrs. ....mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None. Old

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Joseph O'Connell

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Annapolis

12-MAIDEN NAME OF MOTHER, Mattie Seymour

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14-

(Informant) Joseph O'Connell

(Address) 122 Patapsco

JAN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1923 to Jan 10 1924

that I last saw her alive on Jan 8 1924

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(Duration) no yrs. 12 mos. 18 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Stools

(Signed) Reynold D. Hamm M. D

Jan 10, 1924 (Address) Fallsway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cemetery	Jan. 11, 1923
20-UNDERTAKER.	ADDRESS
A. Sanders & Sons	1710 Fleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82608

CERTIFICATE OF DEATH.

3 D 82608

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 26 ST., WARD)

2-FULL NAME William L Kaiser

(a) RESIDENCE NO. 120 S Bouldin St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5-1923

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ludwig Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Kessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 - , 1924, to Jan 10 , 1924 that I last saw ~~him~~ alive on Jan 10 , 1924, and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

General Miliary tuberculosis

(duration) yrs. mos 13 ds.+

CONTRIBUTORY (Secondary) Tuberculosis meningitis

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Wood, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Larraine Cemetery — DATE OF BURIAL Jan 12 1924

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82609

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 410 S. Madeira St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teodore Borsukiewicz

(a) Residence No. 1719 Gough St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Wincentyna Borsukiewicz

6-DATE OF BIRTH (month, day and year) April 1 1868

7-AGE.	If LESS than 1 day,
55 yrs. 9 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Wawrzyn Kaszura

(Address) 1719 Gough Street

15- Filed Jan 11 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 10/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1924 to ..... 19.....

that I last saw h... alive on Jan 10 1924

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurg and Nephritis

(Duration) 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) T F Rees M. D

Jan 11 1924 (Address) 24 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER: John M Weber ADDRESS 1803 Bank St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82610

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter McGlone

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9, 19 24

17

I HEREBY CERTIFY, That I attended deceased from May 6, 19 19, to January 9, 19 24, that I last saw him alive on January 8, 19 24, and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Dean, M. D.

-10-1924 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cem	1/11/24
20 UNDERTAKER	ADDRESS
J. J Bakey & Sons	318 Light St

GIVE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82611 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82611

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter McDonough

(a) Residence No. ~~Unknown~~ York Rd. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1848

7-AGE.	If LESS than 1 day,
75 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS:
10-NAME OF FATHER, John McDonough
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Anna Gold
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Municipal Hospital Record
(Address)

15- Filed JAN 1 1924 192 Robert F. Murrison Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from November 9, 19 23 to January 9, 19 24
that I last saw h. in alive on January 8, 19 24
and that death occurred, on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma - Right hand.
- Metastasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan. 8, 1924
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm. J. Fulton, M. D
1-10-, 19 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, 1-V 19 24

20-UNDERTAKER. ADDRESS 318 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82612

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Light St.: W3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Cleary

(a) RESIDENCE. NO. 1612 Light St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): U.H.R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos Cleary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary McCall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: E. Cleary
(Address): 1612 Light St.

15 Filed JAN 1 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to Jan 10, 1924, that I last saw him alive on Jan 9, 1924, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. L. Steigen, M. D.

1/11, 1924 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic	1/14 1924
20 UNDERTAKER: John J. Daly & Sons	ADDRESS: 1316 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Herold)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82613

D 82613

CERTIFICATE OF DEATH.

REGISTERED NO. C 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 N. Robinson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Herold

(Residence in Baltimore: No. 27 N. Robinson St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, 8 (Month) 3 (Day) 1867 (Year)

7-AGE, 66 yrs. 5 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Anthony Herold

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Mary A. Shrader

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Herold

(Address) 723 N Wolfe St

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

JAN 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1923, to Jan 10 1924, that I saw h alive on Dec 28 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Jan 11, 1924 (Address) 1917 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	January 12, 1924
20-UNDERTAKER	ADDRESS
Randall Pryfelsdon	378 Mn

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 82614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 N. Bond St ST., 7 WARD)

REGISTERED NO. 181

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Hennelly

(a) RESIDENCE No 821 N. Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hennelly

6 DATE OF BIRTH (month, day, and year) Mar 15/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant William Hennelly

(Address) 821 N. Bond St.

Filed JAN 1 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas-asphixation
(Accidental- Coffee pot boiled over and extinguished blaze)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

(Signed) J. S. H. Rocks, M. D.
(Coroner.)

Jan 11/24 (Address) 508 E. North Avs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	1/12 1924
20 UNDERTAKER	ADDRESS
George J. Ruth	1930 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.F.S.—400 Bks.

Givehaus 1305-Lc SC

D 82615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 3/4 D 82615

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 N. Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Hay

(a) Residence No. 704 N. Fayette St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M. | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 4 1869

7-AGE, 54 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer. American Co.

9-BIRTHPLACE (city or town)..... (State or Country). Balto

PARENTS.

10-NAME OF FATHER, John Hay

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellen Albert

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14-

(Informant)

(Address) 2213 N. Central

15-

Filed JAN 11 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 10 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Jan 10 1924

that I last saw h. liv. alive on Jan 9 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Some History (Duration) One yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Grosbans M. D

Jan 10, 1924 (Address) 3100 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Trinity Cem. | DATE OF BURIAL, 1/14 1924

20-UNDERTAKER Wm Cook | ADDRESS 932 E. Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAYFIELD

Cor.—1-12-23—M&T—100 Bks.

Morrison, Robert Guy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82616 — D 82616

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial St. Wards WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Kane

(a) RESIDENCE NO. Park Hts Ave Exc- Exclusive WARD Ecleston Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie G.

6 DATE OF BIRTH (month, day, and year) June 18 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer Wm E. Blackwood

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER John Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Annie Kane
(Address) Ecleston Md

15 Filed JAN 1 1924 192 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
Obstruction of Intestine 3 days
12 hours

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) John H. Bruns M. D.
(Coroner.)
Jan 10 1924 (Address) 592 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan. 12 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E. Lt. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 82617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82617

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Enroute to

CITY OF BALTIMORE: (No. 1542 N. Wolf ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie A Brooks

(a) RESIDENCE No. 1542 N. Wolf ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Preston S

6 DATE OF BIRTH (month, day, and year) Oct 16 186[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George A Polis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Augusta Hillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Preston S Brooks
(Address) 1542 N Wolf St

15 Filed ..... 192 Robert P. Harrison, Registrar

JAN 11 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilitation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. [illegible] Coroner, M. D.

Jan 11 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Patterson Park	Jan 14 192[illegible]
20 UNDERTAKER	ADDRESS
H. W. Cook	502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

lf 82618

CERTIFICATE OF DEATH.

D 82618

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victory Jackson

(a) RESIDENCE NO. Glencoe Md ST., ... WARD Glencoe Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ ?

6 DATE OF BIRTH (month, day, and year) 1859.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ~~Victor~~ John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 FEB 1 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Jan 24, 1924, that I last saw h— alive on Jan 24, 1924, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

Senility

Symptoms (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Glencoe, Md.

Did an operation precede death? yes Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) Reginald Black, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louch Church Balto Co	Jan 27 1924
20 UNDERTAKER	ADDRESS
W C Brooks	Sparks Md

JAN 1924

FOR WHITE PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82619

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2717 W. North Ave ST., 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Capt. Edwin F. Greene

(a) RESIDENCE No. 2717 W. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. - mos. - ds. How long in U. S., if of foreign birth? 62 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma E. Greene

6 DATE OF BIRTH (month, day, and year) May 16 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer U. S. Shipping Board

9 BIRTHPLACE (city or town) Wales (State or country) England

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER - Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) F. A. Greene 737 W. Northaven

15 Filed JAN 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan - 6 - , 1924, to Jan - 9 , 1924, that I last saw h. alive on Jan - 9 - , 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marius W Stock M. D.

Jan 10. 1924 (Address) 8064 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Jan 12 1924

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North Ave

INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... s on back of certificates.

D 82620 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1708 Westwood Ave. St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Marsden Rodgers

(Residence in Baltimore: No. 1815 W. Fulton Ave. St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, October (Month) (Day) 1852 (Year)

7-AGE, 71 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Marsden

11-BIRTHPLACE OF FATHER, (State or Country), United States of America.

12-MAIDEN NAME OF MOTHER, Eliza Elton

13-BIRTHPLACE OF MOTHER, (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer W. Rodgers.

(Address) 1705 Poplar Grove St.

15- Filed JAN 12 1924 Robert P. Harrison, Registrar.

Trial Forest Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 10 (Month) (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Unknown) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

1-11 1924 (Address) 2302 Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Jan 14 1924
20-UNDERTAKER.	ADDRESS.
Joseph P. Cook	1003 N. Bolton St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82621

CERTIFICATE OF DEATH.

31 D 82621

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 Kennedy ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helvo Grace Roeder

(Residence in Baltimore: No. 2017 Kennedy ave St.; 23 yrs., 5 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 19, 1900
(Month) (Day) (Year)

7-AGE, 23 yrs. 5 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

037

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank C Von Hone

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna B Jennings

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas B Roeder

(Address) 2017 Kennedy Ave

15-

Filed JAN 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 10, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 3 1923, to January 10 1924, that I saw her alive on January 10 1924, and that death occurred, on the date stated above, at 10.25 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. mos. ds.

(Signed) J S Hall M. D.

1-10, 1924 (Address) Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cem — DATE OF BURIAL, Jan 12, 1924

20-UNDERTAKER Lee L. B Cook — ADDRESS 1003 N Balto St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82622

90 D 82622

CERTIFICATE OF DEATH.

20

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2500 Frederick Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Louis Frederick Meyer .....

(a) Residence No. 2500 Frederick Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Meyer

6-DATE OF BIRTH (month, day and year) July 5, 1875

7-AGE.	If LESS than 1 day,
48 yrs. 6 mos. 5 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Barber .....

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 004

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), New York

PARENTS.

10-NAME OF FATHER, Charles F. Meyer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Strauckle John

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)... Mrs. Mary E. Meyer.....

(Address)..... 2500 Frederick Ave.....

15-

Filed ..... Robert P. Harrison,
Registrar.

JAN 1 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... Nov ..... 19 14 to ..... Jan 9 ..... 19 24

that I last saw h[illegible] alive on ..... Jan 9 ..... 19 24

and that death occurred, on the date stated above, at 2.05 A.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ✓ Date of.....

Was there an autopsy? ✓

What test confirmed diagnosis? .....

(Signed) ..... Emmett Rahm ....., M. D.

1-10 1924 (Address) 910 N. Mount St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Jan. 12 1924
20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 N. Gallo St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82623

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 82623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3102 Berkshire Road St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Edith A. Breckenridge

(a) Residence No. 3102 Berkshire Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr. 3, 1923

7-AGE: .....yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George C. Breckenridge

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ethel M. Berger

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-

(Informant) George C. Breckenridge

(Address) 3102 Berkshire Road

15-

Filed ..... 19.. Robert F. Harris, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 10, 1924

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1924 to Jan. 10, 1924

that I last saw h.. alive on Jan. 10, 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Emb. Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Holt Keech, M. D.

1-11, 1924 (Address) 305 N. Calhoun St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	Jan 12, 1924
20-UNDERTAKER,	ADDRESS
John B. Cook	1003 W. Balto

Sa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.R.R.S.—400 Bks.

D 82624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82624

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) New Howard Hotel (St.) Room (Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Hardy

(a) Residence No. 19 Franklin St. (St.) Annapolis Maryland (Ward) Annapolis Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline C. Hardy

6-DATE OF BIRTH (month, day and year) Jan. 27, 1862

7-AGE.	If LESS than 1 day.
61 yrs. 11 mos. 15 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Secretary to Gov.

(b) General nature of Industry, business, or establishment in which employed (or employer): Gov. Ritchie

(c) Name of employer: Gov. Maryland

9-BIRTHPLACE (city or town) (State or Country): Columbus Ohio

PARENTS.

10-NAME OF FATHER: Charles J. Hardy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Columbus Ohio

12-MAIDEN NAME OF MOTHER: Sarah Buttle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Columbus Ohio

14- (Informant) Mrs. Pauline C. Hardy

(Address) 19 Franklin St. Annapolis Maryland

15-

Registrar.

JAN 21 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 19[illegible]3, 1923 to January 11, 1924 that I last saw h[illegible] alive on January 11, 1924 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Complications of Paralysis with Nephritis (a) Acute Dilatation, and (c) 9th Rib on left chest.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and X ray

(Signed) Edgar S. Perkins M. D.

1-11, 1924 (Address) The Rochambeau Apts.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Jan 14 1924
20-UNDERTAKER.	ADDRESS.
Jos. L. Cook	1003 N. Bath

SX

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82625

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

D 82625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 N. Patterson Park ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Greil

(a) RESIDENCE NO. 1719 N. Patterson Park ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis C Greil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Katherine B. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Louis C Greil
(Address) 1719 Patterson Park ave

15 Filed Robert P. Harrison Registrar

N 1 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 11, 1924, that I last saw h m alive on Jan 10, 1924, and that death occurred, on the date stated above, at 155 a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(over)

(duration) yrs. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M. D.

1/11, 1924 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 14th 1924

20 UNDERTAKER ADDRESS

George Schulting & Sons 1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82626

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D 82626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1276 Battery Ave. St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Struth

(a) Residence No. 1276 Battery Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 0 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the Word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 25 1847

7-AGE. 76 yrs. 0 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Katharine Reinig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) Mrs. Allen (sister)

(Address) 1276 Battery Ave.

15-

Filed JAN 21924 19..

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923 to Jan 11, 1924

that I last saw him alive on Jan 10, 1924

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac asthma

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral arterio-sclerosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. P. Harrison M. D

1/12/24 (Address) 1 E Randall St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Lorraine Cemetery	1/14 19.24
20-UNDERTAKER,	ADDRESS
J. Fenw McCully	130 E. Fort

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001 82627

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 719 S Lakewood Ave Ward) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Helida Phelps

(a) Residence No. 719 S Lakewood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 30/23

7-AGE, ...yrs. 4 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Phelps

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Stella Lowder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mother

(Address) 719 S Lakewood Ave

Filed JAN 21 1924 19.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 11/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 9, 19 24 to Jan 11, 19 24 that I last saw h. alive on Jan 11, 19 24 and that death occurred, on the date stated above, at 2.30 PM

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) Edward Phelps M.D.

, 19 (Address) 100 N Linwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL, Jan 12, 1924

20-UNDERTAKER, J W Ozarowski — ADDRESS 1925 Eastern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82628

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Eastern Ave. ST.; V WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Frank Piorunski.

(a) RESIDENCE. NO. 2021 Eastern ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white.	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) January 7 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Leo Stanley Piorunski.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Frances Cwirk.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md

14 Informant Leo F. Piorunska
(Address) 2021 Eastern Ave

15 Filed JAN 21 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11 1924

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1924, to January 11, 1924, that I last saw him alive on January 11, 1924, and that death occurred, on the date stated above, at 11.00 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(91)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Congenital debility
(151) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Typical signs & S.

(Signed) James Graham Manton M. D.

1-11, 1924 (Address) 814 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 12 1924
20 UNDERTAKER	ADDRESS
F. M. Wazenski	1950 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82629

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82629

100-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Dukeland Ave St. 16 WARD)

2-FULL NAME Audrey Patterson

(a) RESIDENCE NO. 907 Dukeland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25-1923-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	3	17da	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Linwood Patterson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Virginia Abl

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Laura V. Patterson

(Address) 907 Dukeland Ave.

Dec 21 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11- 1924.

17

I HEREBY CERTIFY, That I attended deceased from 12-30- , 1923, to January 11- , 1924, that I last saw h e alive on January 10 - , 1924, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland. M. D.

1-11-, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cem	Jan 12, 1924
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	North Ave

— THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 21 1924

D 82630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1794

D 82630

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Colonial Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Rebecca Mayden

(Residence in Baltimore: No. 1029 N. Stricker St.; 24 yrs., 4 mos., 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	married

6-DATE OF BIRTH. Aug. 20, 1899
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
24 yrs. 4 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)... 037

9-BIRTHPLACE, (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Wm. Harper

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary E. Handy

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Harper

(Address) 1029 N. Stricker St

15-

Filed JAN 12 1924

Robert P. Harrison, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 11, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd, & 3rd degree burns of body,

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) coal stove exploded

(Duration)....yrs....mos....ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Jan. 12 1924 (Address) 2802 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Pikesville DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER, Wm. H. Case Sons ADDRESS 1400 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate. may be properly classified. Exact statement of OCCUPATION

D 82631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82631

CERTIFICATE OF DEATH.

Registered No. C 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Harper

(Residence in Baltimore: No. 1029 N. Fulton St., St.; yrs. 4 mos. ~~22 ds.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	single

6-DATE OF BIRTH, Aug. 14, 1919 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 4 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frank Mercer

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Oneita Harper

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Harper

(Address) 1029 N. Fulton Ave

15- JAN 12 1924 Robert P. Haffiger, Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 12, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~inquest~~ inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd, & 3rd. degree burns of body

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Complications unknown

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 12, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peters. DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER, John W. Cluse ADDRESS 1400 Mosher

D 82632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82632

CERTIFICATE OF DEATH.

90 6

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 N. Castle St., 6 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Francis Musil

(Residence in Baltimore: No. 427 N. Castle St.; yrs. 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

6-DATE OF BIRTH. June (Month) 4 (Day) 1862 (Year)

7-AGE. 61 yrs. 7 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER. Joseph Kliment

11-BIRTHPLACE OF FATHER, (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Musil Jr

(Address) 1218 N Walton Ave

15-

Filed JAN 1 1924

Robert P. Harrison, Registrar.

Partial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 9 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said decased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chronic Myocarditis or Endocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Dallin M. D.
(Coroner)

June 11 1924 (Address) 508 E. North Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn — DATE OF BURIAL, 1/12 1924

20-UNDERTAKER, Philip Herwig — ADDRESS 2016 Orleans

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82633

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH Colonial Hosp.

CITY OF BALTIMORE: (No. 1112 N. Thrond ST. 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Dungan

(a) RESIDENCE NO. 15 N. Stricker ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred last entire life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? ?

7 AGE Years 70 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria, Va.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Irving Dungan - son (Address) 15 N. Stricker St.

15 Robert P. Harrison, Registrar

JAN 21 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1923, to Jan. 10, 1924, that I last saw h[illegible] alive on Jan. 10, 1924 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Interarticulation of Cervical Vertebrae

Caseous intervertebral Parenchymatous

several years

(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis - pneumonia

4 days (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray examination

(Signed) A. A. Hirschman, M. D.

, 19 (Address) Resident, Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 1/13 1924

20 UNDERTAKER Robert Brooks & Son — ADDRESS 1725 Calhoun St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3508 Calloway Ave St., 15 Ward)

Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dodye Mary Nichols

(a) Residence No. 3508 Calloway Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alton T. Nichols

6-DATE OF BIRTH (month, day and year) Apl 1-1882

7-AGE, 41 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Alton T. Nichols

(Address) 3508 Calloway Ave

15- Robert F. Harrison,

Filed ..... 192..... Registrar.

JAN 1 21924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 11-1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 1 1923 to Jany 11 1924

that I last saw h. alive on Jany 11 1924

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis - Acute Infly

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failing Compensation

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. L. Donna, M. D.

Jany 22 1924 (Address) 1228 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER, T. Edward Lee

ADDRESS 1723 W Fay

All statements should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82635

CERTIFICATE OF DEATH.

+ 136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Francis.

(a) RESIDENCE NO. U.S. Marine Hospital ST., WARD Ship

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Un known

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman.

(c) Name of employer Un known

9 BIRTHPLACE (city or town) (State or country) British West Indies

PARENTS

10 NAME OF FATHER Un known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un known

12 MAIDEN NAME OF MOTHER Un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un known

14 Informant Self.

(Address)

Filed JAN 21 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1923, to January 10, 1924.

that I last saw him alive on January 10, 1924

and that death occurred, on the date stated above, at 11.25 a.m.

The CAUSE OF DEATH* was as follows:

Granuloma, fungoides. Inguinal regions, Epithelioma.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Un known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. H. Foster, M. D.

1/10, 1924 (Address) U.S. Marine Hospital #1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 1/16 1924

20 UNDERTAKER J. Shinson & Bro

ADDRESS 1127 E Balto St

INSTRUCTIONS—THIS STATEMENT, WITH UNDERSTANDING, EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82636

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Frank

(a) RESIDENCE No. 2323 E. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Frank.

6 DATE OF BIRTH (month, day, and year) Dec 2. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	64	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. Russ

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Soellner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Conrad Schroeter

(Address) 2323 E. Monument

15 Filed JAN 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11- 1924

17 I HEREBY CERTIFY, That I attended deceased from January 3 1923 to January 11 1924

that I last saw him alive on January 11 1924

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

Chronic Cholecystitis

Cholelithiasis (duration) unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma of Omentum (duration) unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan 10

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Sig.) James R. Wilkerson, M. D.

19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash. D. C. DATE OF BURIAL Jan 15 1924

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 84 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82637

10-09 82637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Bolton ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Brooks

(a) RESIDENCE No. 1137 Bolton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co Va
(State or country)

PARENTS

10 NAME OF FATHER Dennis Brooks

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Brooks

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Hattie Chew 1137 Bolton St
(Address)

15 Filed JAN 21 1924, 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 10, 1924, that I last saw her alive on Jan. 10, 1924, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Oil-stove smoke

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheeler, M. D.

1/12, 1924 (Address) 1230 S. Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 1/12 25

20 UNDERTAKER Samuel Hawley ADDRESS 814

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82638

CERTIFICATE OF DEATH.

38 D 82638

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Little Monument ST., 11 WARD)

2-FULL NAME Maggie A. Smith -

(a) RESIDENCE No. 810 Little Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jefferson Smith -

6 DATE OF BIRTH (month, day, and year) Apr 23. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Beverly Archer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville Ky

14 Informant ..... (Address) Julia A. Wood 1 Lexington Ave. N.Y. City -

15 Filed ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1923, to Jan 10th, 1924.

that I last saw her alive on Jan 7th, 1924,

and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Cystitis & Stomach Disorders

Instantaneous (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Psychosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

1/11, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL 1/13/24

20 UNDERTAKER Scarff & Crawley ADDRESS [illegible]

GRANT 21874

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82638

CERTIFICATE OF DEATH.

38 D 82638

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Little Monument ST., 11 WARD)

2-FULL NAME Maggie A. Smith -

(a) RESIDENCE No. 810 Little Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jefferson Smith -

6 DATE OF BIRTH (month, day, and year) Apr 23. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Beverly Archer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville Ky

14 Informant ..... (Address) Julia A. Wood 1 Lexington Ave. N.Y. City -

15 Filed ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1923, to Jan 10th, 1924.

that I last saw her alive on Jan 7th, 1924,

and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Cystitis & Stomach Disorders

Instantaneous (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Psychosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

1/11, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL 1/13/24

20 UNDERTAKER Scarff & Crawley ADDRESS [illegible]

GRANT 21874

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 82639

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-006 82639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Jordan St. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma J. Harris

(a) RESIDENCE NO. 919 Jordan St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) about 1863 Jan. 1

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Dr. D. F. Moor
(Address) 2101 N. Broadway

15 Filed ... 192 Robert P. Harris City Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Kidney

(duration) ... yrs. ... mos. ... ds.

(Signed) D. J. Hennessy, M. D.
(Coroner.)

Jan. 8, 1924 (Address) 2102 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL 1/12 1924

20 UNDERTAKER Samuel D. Ward ADDRESS W. Balt

Burial Permit ...

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Spencer

(a) Residence No. 16 Orchard St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word)
Male	Colored	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1851

7-AGE	If LESS than 1 day
62 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Spencer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jane Riddy

12-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

13- (Informant) Municipal Hospital Records

(Address)

Filed JAN 12 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from November 14 19 23 to January 8 19 24

that I last saw him alive on January 8 19 24

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection of Left Knee

(Duration) yrs. 4 mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 10, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

1-9- 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1/12 19 24
20-UNDERTAKER, Samuel T. Hearst	ADDRESS 578 N. Bond

CORONER FOR CITY-EASTERN DISTRICT

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82641

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82641

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 255 N. Payson ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Christian Catt

(a) RESIDENCE NO. 255 N. Payson ST., 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Catt.

6 DATE OF BIRTH (month, day, and year) Dec. 21 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lord Balto Press

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Catt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Carrie Catt.

(Address) 256 N. Payson

15 JAN 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Jan 10, 1924, that I last saw h. alive on Jan 10, 1924, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pt Hemiplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

1/13/24 (Address) 2027 Wadsworth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 12 24
20 UNDERTAKER	ADDRESS
Jos Joesdens Son	2178 Pa.

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—8-24-14—M. & T.—2000 Blks.

D 82642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82642

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Somerset ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida L. Jackson

(Residence in Baltimore: No. 422 Somerset St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 4 (Day), 1871 (Year)

7-AGE, 53 yrs. 6 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) House wife 037

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Proctor

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Probree

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Chas L. Jackson Husband

(Address) 422 Somerset st

15- Filed ....., 191.....
Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N 1 21924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 11 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1923, to Jan 11 1924, that I saw h[er] alive on Jan 10 1924, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 ..... ds.

(Signed) ..... M. D.

1/11, 1924 (Address) 1429 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Jan 15, 1924

20-UNDERTAKER Mrs. R. C. Elliott — ADDRESS 172 Eastlands

AGE should be stated EXACTLY. PHYSICIAN should carefully note all information should be carefully supplied. AGE properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be

Spec.—1-10-21—M&T—1500 Blks.

D 82643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82643

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

2-FULL NAME Cyrus James

(a) RESIDENCE NO. 1032 Booth St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Oth

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER James James

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER C. Douglas

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant ..... Hospital Record
(Address)

15 Filed ....., Robert P. Harrison, Registrar
Burial Permit Clerk.

JAN 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9/24 19

17 I HEREBY CERTIFY, That I attended deceased from 12/19/23, 19 ..... to 1/9/24, 19 .....
that I last saw h~~e alive~~ on 1/8/24, 19 .....
and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Mitral Insufficiency

(duration) 2 yrs. mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. W. Greley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Jan 24 1924

20 UNDERTAKER: Mark R. C. Elliott — ADDRESS: 225 Cathedral

IMPORTANT—THIS CERTIFICATE, PARTICULARLY THE ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 16 D 82644

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No 1506 Presstman St. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Berry

(Residence in Baltimore: No. 1506 Presstman St. St.; yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH. June 7 (Month) (Day) 1924 (Year)

7-AGE. 3 ds. yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Herman Berry

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Margaret Rast

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Berry

(Address) 1506 Presstman St.

15. Filed JAN 12 1924, 192. Robert P. Harrison, Registrar. ~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 9 (Month) (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Haemophilia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Hemorrhage from umbilical cord.)

(Duration) yrs. mos. 1 ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan. 10 192 (Address) 2802 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Lebanon Cemetery. DATE OF BURIAL. Jan 12 19 24

20-UNDERTAKER. Jas H Hennis ADDRESS 1303 Presstman St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82645

D 82645

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 McDonough ST., 7 WARD)

2-FULL NAME Mary E. Johnson

(a) RESIDENCE NO. 1008 McDonough ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 69

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Blocklock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co

14 Informant Mrs Rivers
(Address)

15 Filed JAN 12 1924, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1924, to Jan 10th, 1924, that I last saw her alive on Jan 10th, 1924, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Parenchymatous)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. 8 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. F. Lackwood, M.D.

, 19 (Address) 5 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan 14 1924

20 UNDERTAKER Geo M Zink & Son

ADDRESS 811 N Wolfe

INFORMATION REQUIRED BY LAW. Every question on this certificate should be answered with the utmost care. AGE should be stated EXACTLY. PHYSICIAN should write plainly. Words may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82646

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 9 ST., WARD)

2-FULL NAME John E Keating

(a) RESIDENCE No. 2541 Old York St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 27 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Agnes Caffey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 FILED JAN 12 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Jan 11, 1924, that I last saw h[illegible] alive on Jan 11, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Vomiting with acetone-body acidosis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) X Diphtheria (pharyngeal)

(duration) yrs. mos. 5? ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Urine + blood analyses

(Signed) H. H. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 17th 1924

20 UNDERTAKER E. J. Fanning ADDRESS 1938 E. Lafayette Ave.

INSTRUCTIONS—THIS IS A PERMANENT RECORD. EVERY ITEM of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 82647

D 82647

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 82647

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 20 WARD)

2-FULL NAME William W. Edwards

(a) RESIDENCE No. 320 S. Monroe St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Dec. 10 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Roofer

(b) General nature of industry, business, or establishment in which employed (or employer) 84

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER William W. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Municipal Hospital Records. (Address)

15 JAN 13 1924 Burial Permit Clerk. Issued R. KRAUER.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1923, to January 11, 1924, that I last saw him alive on January 10, 1924, and that death occurred, on the date stated above, at 1:15 A.M. The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym.

(Signed) Claude G. Dame, M. D.

1-11-24 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dare de Grace	Jan 12 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	Mt. Ethel Pa.

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82648

CERTIFICATE OF DEATH.

66

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1626 Argyle Ave. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Page

(Residence in Baltimore: No. 1626 Argyle Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: Jan. (Month) 26 (Day) 1883 (Year)

7-AGE: 40 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Long Shore Man
(b) General nature of industry, business, or establishment in which employed (or employer): 07

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Augustus Page

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Susie Taylor

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertina Page

(Address) 1626 Argyle Ave.

15 FILED JAN 13 1924 ROBERT L. BO... Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 11 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 12 1924 (Address) 2802 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Robt. Burns

DATE OF BURIAL, 1/13/24

20-UNDERTAKER: Jas. A. Dennis

ADDRESS 1303 Russ... Ave

A. 2—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 82649

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO.

CITY OF BALTIMORE (No. ... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Pulley

(a) RESIDENCE NO. 1531 E. Madison ST., ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 44 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or WIFE of): Georgette Pulley

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 44 Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): do

14 Informant (Address): Bayview Hospital

15 Filed JAN 13 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 9. 1924

17 I HEREBY CERTIFY That I attended deceased from Dec. 9. 1923 to Jan 9. 1924 that I last saw h[illegible]ve on Jan 9. 1924 and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

... (duration) yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) General Paralysis Insane (Cirrhosis) (duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Insane

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autological

(Signed) H. Goldsmith Pathologist, M.D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 14 1924

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82656

CERTIFICATE OF DEATH.

84 D 82656

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Guilford Ave. ST., 17 WARD)

2-FULL NAME Norbourn A. Thomas.

(a) RESIDENCE NO. 3103 Guilford Ave. ST., WARD

(Usual place of abode) Lifetime (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose G. Thomas

6 DATE OF BIRTH (month, day, and year) June 17th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness Manufacterer.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Cornelious Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Mary Clare Boarman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Rose G. Thomas

(Address) 3103 Guilford Ave.

15 JAN 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10- 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1923 to Jan 10, 1924

that I last saw h alive on Jan 10, 1924,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

8hrs (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ... yrs. ... mos. 27 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

1/12, 1924 (Address) 2027 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/14-1924
20 UNDERTAKER	ADDRESS
Chas. H. Grace & Son	1118 N. Eutaw St.

N. B.—WHITE PAPER ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82651

CERTIFICATE OF DEATH

1-PLACE OF DEATH Church Home + Infirmary

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Francis E. Allegre

(a) RESIDENCE No. Arbutus Md ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred not known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Rebecca Allegre

6 DATE OF BIRTH (month, day, and year) March 16 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Priest

(b) General nature of industry, business, or establishment in which employed (or employer) Rector of Parish

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) London England

PARENTS

10 NAME OF FATHER Alex McAllegre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Devonshire England

12 MAIDEN NAME OF MOTHER Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary E. Ellett

(Address) Lawson Springs Ky

15 FILED JAN 31 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1923, to Jan 11, 1924,

that I last saw him alive on Jan 11, 1924,

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Division & Union on Diag

(Signed) K. A. Reed, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 14 1924
20 UNDERTAKER Henry H. Jenkins Sons Co	ADDRESS McCulloh & Orchard Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 - 001 ✓

D 82652

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Cathedral ST., 11 WARD)

2-FULL NAME Charles Church Harris

(a) RESIDENCE NO. 925 Cathedral ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) 1863?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist 055

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisonburg Va

PARENTS

10 NAME OF FATHER Jas. H Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrisonbg Va

12 MAIDEN NAME OF MOTHER Rosenbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Howell H Thomas
(Address) 3912 Clovehill Rd

15 Filed JAN 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11th, 1924, to Jan 11th, 1924, that I last saw him alive on Jan 11th, 1924 and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 da.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. diagnosis

(Signed) J B Entelhauer M. D.

1/12, 1924 (Address) 1901 Eutaw Pl.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Jan 14th 1924
20 UNDERTAKER	ADDRESS
A M Jenkins & Son Co.	Cathedral & The Colleges

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82653

CERTIFICATE OF DEATH.

74-001 ✓ D 82653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Bolton ST., 11 WARD)

2-FULL NAME Mary Henshaw Grosvenor

(a) RESIDENCE No. 1208 Bolton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced (~~write the word~~): Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: Robert Grosvenor

6 DATE OF BIRTH (month, day, and year): 1855-19-1

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady 037

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Robert Clinton Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Selina Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Robert C Wright

(Address): 1208 Bolton St.

15 Filed JAN 3 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1924, to Jan 11th, 1924, that I last saw her alive on Jan 11th, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Coma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. P. Lockwood M. D.

1/12/1924 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas Garrison Forest — DATE OF BURIAL: 1-14 1924

20 UNDERTAKER: Henry W. Justice & Sons Co — ADDRESS: Mulberry & Greene

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 80 82654

CERTIFICATE OF DEATH.

X 11-001 D 82654

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Crawford Messenger

(a) RESIDENCE No. Benges P.O. Middle River Md. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David A Messenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Earl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 31 1924 ROBERT R. KRAUS

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Jan 11, 1924, that I last saw h.. alive on Jan 11, 1924, and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows: Acute Meningitis (B. Influenzae)

(duration) yrs. ..... mos 2 3 ds.

CONTRIBUTORY (Secondary) Acute Secondary Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bagg, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orem Cemetery — DATE OF BURIAL: Jan. 13 1924

20 UNDERTAKER: Fred Fossa & Son — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82655

CERTIFICATE OF DEATH.

129 D 82655

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3376 O'Donnell ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mutschler

(a) RESIDENCE NO. 3376 O'Donnell St ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Mutschler

6 DATE OF BIRTH (month, day, and year) Feb. 8- 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Gerhard Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Helena R Lyfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Christian Mutschler

(Address) 3376 O'Donnell St

BURIAL PERMIT ISSUED

15 JAN 13 1924

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1923, to Jan 10, 1924

that I last saw her alive on Jan 10, 1924

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hepatitis -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) W J Gerry -, M. D.

(Address) 69 W Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 14 1924

20 UNDERTAKER Lilly F Feiler

ADDRESS 4038 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82656

CERTIFICATE OF DEATH.

90 D 82656

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N. Luzerne ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony J. Voith

(a) RESIDENCE No. 808 N. Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Voith

6 DATE OF BIRTH (month, day, and year) May 29/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing M'f'g
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Comtractor 016

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Voith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa Voith
(Address) 808 N. Luzerne St.

15 JAN 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insuffiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Collins, M. D.
(Coroner)

Jan 12/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan 16th 1924
20 UNDERTAKER Lilly & Feder	ADDRESS 4038 Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

D 82657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002 ✓

D 82657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Provident Hosp ST., 16 WARD)

2-FULL NAME Florence Maddox

(a) RESIDENCE No. 1336 W. Lafayette Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert F Maddox

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James E Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mckoon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robert F Maddox

(Address) 1336 Lafayette Ave

JAN 1 1924

ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Jan 9, 1924

that I last saw h er alive on Jan 9, 1924

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal obstruction

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Volvulus

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death? 1336 W. Lafayette Av

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S B Hughes M. D.

1923 (Address) 1443 D. Fleet Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1/12 1924

20 UNDERTAKER Samuel Handy

ADDRESS 1178 Eddie

Spec.—1-10-21—M&T—1500 Bks.

D 82658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82658

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel A. Buchner

(a) RESIDENCE NO. 213 N. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Buchner

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Cohen

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Jack Lewis
(Address) 1429 E Baltimore St

JAN 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Jan 13, 1924, that I last saw him alive on Jan 13, 1924, and that death occurred, on the date stated above, at 8:25a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 2 hrs.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Rufus A. Weber M. D.

1/13 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL Jan 13 1924

20 UNDERTAKER Jack Lewis ADDRESS 1409 E Baltimore St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82659

CERTIFICATE OF DEATH.

100-09 V 82659

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1573 Richland ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Levin D Gray.

(Residence in Baltimore: No. 1573 Richland. St.; 11 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Married

6-DATE OF BIRTH. May 2 1875 (Month) (Day) (Year)

7-AGE, 48 yrs. 7 mos. 15 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Auto 086

9-BIRTHPLACE, (State or Country). Bozman Md

PARENTS.

10-NAME OF FATHER, John Gray

11-BIRTHPLACE OF FATHER (State or Country). Phila.

12-MAIDEN NAME OF MOTHER Anna Hunt

13-BIRTHPLACE OF MOTHER (State or Country). Bozman Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Anna Brown

(Address) 1570 Richland st

15- Filed JAN 31 1924, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11 1924, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 30 1923, to Jan 11 1924, that I saw h— alive on Jan 11 1924, and that death occurred, on the date stated above, at 8 40 a. m.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

..... (Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos H Phillips Jr. M. D.

Jan 11, 1924 (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Bozman Md	1/14, 1924

20-UNDERTAKER Thos J Fields 1300 N Fulton ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

D 82660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148 D 82660

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1329 Ramsey St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Maxwell A Schwemmer

(Residence in Baltimore: No. 1329 Ramsey St. 7 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. Dec (Month) 9 (Day) 1897 (Year)

7-AGE. 26 yrs. 1 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE. (State or Country) Virginia

PARENTS.

10-NAME OF FATHER. John P. Franz

11-BIRTHPLACE OF FATHER. (State or Country) Denmark

12-MAIDEN NAME OF MOTHER. Kate Harmon

13-BIRTHPLACE OF MOTHER (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norwood E Schwemmer

(Address) 1329 Ramsey St

15- Filed JAN 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 12 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis Hemoptysis (Puerperal)

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenlon M. D. (Coroner.)

Jan 14 1924 (Address) 700 E Chase

*State the **Disease Causing Death**, or, In deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	July 15 1924
20-UNDERTAKER.	ADDRESS
John J Fields	1001 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82661

CERTIFICATE OF DEATH.

101-001 ✓ SCHOLLIAN

D 82661

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1240 Ridgely St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary A. Schollian (Sheldon)

(Residence in Baltimore: No. 1240 Ridgely St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Nov (Month) 10 (Day) 1917 (Year)

7-AGE. 6 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... [illegible]

9-BIRTHPLACE. (State or Country). Balto. City,

PARENTS.

10-NAME OF FATHER. Joseph Schollian

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Catherine Mann

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Schollian

(Address) 1240 Ridgely St

Filed JAN 3 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 12 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquest find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W. Faut M. D.
(Coroner.)

Jan 13 1924 (Address) 705 E. Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Cross A. & C.	1-14 1924
20-UNDERTAKER.	ADDRESS
James Dignan & Son	1000 E Pleasant St

Spec—12-23-21—E.B.R.S.—400 Bks.

82662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82662

1-PLACE OF DEATH

City of BALTIMORE: No. 4940 Park Heights Ave St. 27 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hockeder

(a) Residence No. 4940 Park Heights Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 18 1869

7-AGE. 54 yrs. — mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Franz Hockeder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER Mary Ruggold

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-
(Informant) Paul Hockeder
(Address) 1211 W. Baltimore St

15-
Filed ..... 192.....

JAN 3 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1923 to Jan 11 1924 that I last saw h. living alive on 1/10 1924 and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart

(Duration) about 14 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. W. Dorsey M. D.

1/12 1924 (Address) 2020 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. Jan 14 1924

UNDERTAKER, John O. Mitchell ADDRESS 1201 W Fayette St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

82663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82663

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 843 University Parkway St., 13 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hollstein

(a) Residence No. 843 University Parkway Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John C. Hollstein

6-DATE OF BIRTH (month, day and year): Feb 2 1835

7-AGE: 88 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS

10-NAME OF FATHER: Samuel W. Naman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Bremen

12-MAIDEN NAME OF MOTHER: Susan Knight

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

11- (Informant): Lucy B. Halls

(Address): 843 University Parkway

12- JAN 13 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jany 18-1924

17- I HEREBY CERTIFY, That I attended deceased from August 14 to 23 to Jan 11 to 24

that I last saw her alive on Jany 10 - 1924,

and that death occurred, on the date stated above, at 2.35 P.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Frame M. D

1/12. 1924 (Address) 2435 Mary Land Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: Jany 14 1924

20-UNDERTAKER: John A. Mitchell

ADDRESS: 1201 N. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 123 ✓

D 82664

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Gen Hospital ST., 11 WARD)

2-FULL NAME Mrs Florence Brown

(a) RESIDENCE NO. 1 Exeter Balto Co ST., Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July. 7 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER Marcellus Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs Florence Brown. Texas Baltimore

JAN 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-11-24

17 I HEREBY CERTIFY, That I attended deceased from 12-20-23 19..., to 1-11-24 19...

that I last saw h... alive on 1-11-24 19...

and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis (duration) 1 yrs. mos. ds.

Uremia

CONTRIBUTORY (Secondary) Influenza (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Clinical.

(Signed) Jno A Stamphire, M. D.

, 19 (Address) 111 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Church Baltimore Co Maryland DATE OF BURIAL Jan 15-1924

ADDRESS

20 UNDERTAKER Herbert C Brooks - Sparks Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

82665 — 3/D 82665

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Park Avenue) (WARD) 14

2-FULL NAME L. May Galbreath

(a) RESIDENCE NO. 1735 ST. Park Avenue WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of C. Irwin Galbreath

6 DATE OF BIRTH (month, day, and year) Feby 28 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua R. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah R. Rankin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant C. Irwin Galbreath

(Address) 1735 Park Avenue Baltimore Md

15 JAN 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15. 1923 to January 12. 1924.

that I last saw h er alive on January 11, 1924.

and that death occurred, on the date stated above, at 5.30 a/m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Morris B. Green M. D.

1/12/1924 (Address) Hamilton Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cemetery Towson Md	Jan 14 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Fayette ave

N. B.—WHEN FILLED, WITH ENDORSEMENT, THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82666

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 82666

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mayo - Mayo

(a) Residence No. 4528 Harford Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) October 1860

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Mayo

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Catherine Layne

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Record

(Address)

JAN 3 1924 ROBERT H. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 3, 1924, to January 11 1924 that I last saw him alive on January 11, 1924 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Mayo M. D

-12-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1/14, 1924
Holy Cross Cemetery	
20-UNDERTAKER Doms Co 16	ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

D. 82667

HEALTH DEPARTMENT—CITY OF BALTIMORE

Gorsuch 29th St Paul 44 D 82667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE, No. 2929 Greenmount St., 9th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie K. Fischer

(a) Residence No. 2929 Greenmount Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Leopold Fischer

6-DATE OF BIRTH (month, day and year): Aug 28-1861

7-AGE: 62 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.
10-NAME OF FATHER: August Graf
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Mary Fink
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Europe

11-Informant: Leopold Fischer
(Address): 2929 Greenmount

15-Filed JAN 13 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 11th 1924

17-I HEREBY CERTIFY, That I attended deceased from Jan 1st 1923 to Jan 11th 1924

that I last saw her alive on Jan 11th 1924

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) Anaemia Pernicious

(Duration) 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J. Stanley Gorsuch M.D.

Jan 13 1924 (Address) 2900 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL, 1-15-24

20-UNDERTAKER, William Cook — ADDRESS 502 E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Budnick

82668

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 82668

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Glyndon Ave ST., 21 WARD)

2-FULL NAME Pauline Budnick

(a) RESIDENCE NO. 1329 Glyndon Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Budnick

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER S Goldsholp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Adam Budnick
(Address) 1329 Glyndon Ave

15 Filed JAN 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-11, 1924, to 1-12, 1924

that I last saw her alive on 1-12, 1924

and that death occurred, on the date stated above, at 39 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hyman Drucker M. D.

, 19 (Address) 1119 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Riverside N. J.	1/14/24
20 UNDERTAKER Geo Lembach & Son	ADDRESS 647 W Pratt St

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82669

CERTIFICATE OF DEATH.

128 D 82669

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 231 N Montford ave ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hicks

(a) RESIDENCE. No. 231 N Montford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 2 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Sula

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annie Hicks
(Address) 231 N Montford ave

15 Filed JAN 31924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 9, 1924, that I last saw him alive on Jan 9, 1924, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Adolph C. Eisenbarth, M. D.

Jan 11, 1924 (Address) 1201-03 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 13th 1924

20 UNDERTAKER ADDRESS

Miller Davis 815 N Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

165-748 D 82670

CERTIFICATE OF DEATH.

100-001 D 82670

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Eolbeck

(a) RESIDENCE NO. 27 N. Belnord Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Eolbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dora Smyth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 3 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 7 1923, to Jan 12, 1924.

that I last saw h.. alive on Jan 12, 1924.

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity Life

Otitis Media - 6 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Boarding home - On hospital after 1st.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. N. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Jan 14 1924

20 UNDERTAKER Wendell Diffel & Son — ADDRESS 378 N

INFORMATION—THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 82671

1-PLACE OF DEATH

City of BALTIMORE: (No. 1706 Byrd St., 24 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Byrne

(a) Residence No. 1706 Byrd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Byrne

6-DATE OF BIRTH (month, day and year) Dec 12, 1853

7-AGE, 70 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Andrew McCann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-

(Informant) Peter Byrne

(Address) 1706 Byrd St

15- FILED JAN 13 1924 ROBERT N. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 11. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Jan 11, 1924, that I last saw h... alive on Jan 11, 1924, and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Hemiplegia

Cerebral Hemorrhage

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) High Blood Pressure Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D.

Jan. 11, 1924 (Address) 1233 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cemetery — DATE OF BURIAL, Jan 14, 1924

20-UNDERTAKER, Margaret A Flynn — ADDRESS 1422 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82672

CERTIFICATE OF DEATH.

D 82672

+58-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 14 WARD)

2-FULL NAME Joseph Abate

(a) RESIDENCE NO. 1307 Pennsylvania ave ST., ... WARD .....
(Usual place of abode) Washington D.C.
Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, (Married) Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 15 1884

7 AGE: Years 39 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Abate

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Joseph Abate
(Address) 1307 Pennsylvania Ave N.W.

JAN 4 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-13 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-9 1924, to 1-13 1924, that I last saw him alive on 1-13 1923, and that death occurred, on the date stated above, at 7.15-P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. Raymond Nelson M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery. Washington D.C.

DATE OF BURIAL: Jan. 14 1924

20 UNDERTAKER: Spencer - J. Ruth

ADDRESS 1735 Hayford ave

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82673

HEALTH DEPARTMENT—CITY OF BALTIMORE

124

D 82673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. No Ward) St.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel C. Toland

(a) RESIDENCE NO. 625 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Toland.

6 DATE OF BIRTH (month, day, and year) March 4-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lead Burner.

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Hugh Toland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Elizabeth Toland.

(Address) 625 S. Clinton St.

15 JAN 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Jan 10, 1924, that I last saw him alive on Jan 10, 1924, and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Acute Cholecystitis

Arteriosclerosis + Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 625 S. Clinton St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical Evidence

(Signed) Geo. B. Seybert, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Jan 17 1924

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

107-061

D 82674

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 McCulloh ST., 11 WARD)

2-FULL NAME Julia Lomax

(a) RESIDENCE No. 713 McCulloh ST., 4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Lomax

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Duff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lucy Hunt

(Address) 1003 McCulloh St.

15 JAN 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12th 24

17 I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1924 to Jan. 12th, 1924

that I last saw h.. alive on Jan. 10th, 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Le Roy Ellis, M. D.

1924 (address) 712 Lynwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 1-14 1924

20 UNDERTAKER Daniel Easter

ADDRESS 516 Lemmon

THIS STATEMENT IS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82675

100-001

D 82675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 N. Gilmore ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Braxton

(a) RESIDENCE No. 1103 Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 22 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 9 1792 B

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 1103 Gilmore St (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Braxton

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Beatrice Boyer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14

Informant John Braxton

(Address) 1103 Gilmore St

~~ROBERT R. KRAUTER,~~

JAN 4 1924 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1924, to Jan 11, 1924, that I last saw him alive on Jan 11, 1924, and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank S. Saunders, M. D.

, 19 (Address) 133 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 4th 1924

20 UNDERTAKER Clarence E. Albright

ADDRESS 1649 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Dr. Natsch 2151 Williams ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82676

CERTIFICATE OF DEATH.

129

D 82676

1-PLACE OF DEATH

City of BALTIMORE: (No.) 417 S Smallwood St., 20th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna S. Gebhardt

(a) Residence No. 417 S. Smallwood St., 20th Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE John Gebhardt

6-DATE OF BIRTH (month, day and year) March 12-1860

7-AGE 63 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Henry Kunisch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) John Gebhardt

(Address) 417 S Smallwood

15- JAN 14 1924 19.. ROBERT R. KRAUTH Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1924 to Jan 10 1924

that I last saw h~~e~~ alive on Jan 9 1924

and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Hemaplegia (Apoplexy)

Chr. Interstitial Nephritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Natsch M. D.

Jan 13 1924 (Address) 2151 Williams ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, 1/14/24 19....

20-UNDERTAKER, F. D. Hufnagel

ADDRESS 2256 Fredk ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. 2d Sitch

D 32677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 D 32677

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4527 Park Heights Av St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louise Eckert

(a) Residence No. 4527 Park Heights Av St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Eckert

6-DATE OF BIRTH (month, day and year) April 30th 1846

7-AGE. 77 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Chas. E. Wyanger

(Address) 4527 Park Heights Av

15-

Filed JAN 14 1924 ROBERT R. KRAUTER Clerk (or Asst.)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 10-24

17- I HEREBY CERTIFY, That I attended deceased from Aug 1- 1923 to Jan 10 1924

that I last saw her alive on Jan 9 1924 and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Face. Chronic Parenchymatous Nephritis

(Duration) yrs. Months

CONTRIBUTORY (Secondary) Endocarditis. Pulmonary Oedema (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Robert C. Nitch M. D.

1/13/ 1924 (Address) 2157 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL Jan 14 1924

20-UNDERTAKER, F. B. Kepfield — ADDRESS 2256 Fred'k Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-00

D 82678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S Payson ST. 20 WARD)

2-FULL NAME Norman N. Morrisett

(a) RESIDENCE NO. 624 S. Payson ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howard Morrisett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susie M. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Howard Morrisett

(Address) 624 S Payson St

15 JAN 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany 1, 1924. to Jany 11. 1924.

that I last saw him alive on Jany 10, 1924.

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

Streptococcus Meningitis

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) MacNeill M. D.

1/23, 1924 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlawn Cemetery

DATE OF BURIAL Jany 14, 24

20 UNDERTAKER F. B. Wippert

ADDRESS 2236 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82679

CERTIFICATE OF DEATH.

90 ✓ D 82679

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Allen.....

(a) Residence No. 1412 May St St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Allen

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER, Richard Allen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Lucinda Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant) Municipal Hospital Records

(Address)

15-

Filed JAN 4 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 3 1924 to January 10 1924

that I last saw him alive on January 9 1924,

and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Draper, M. D

1-10-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cemetery — DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER Mrs R.C. Elliott — ADDRESS 1725 Eastland

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so th. it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back o. certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82680

CERTIFICATE OF DEATH.

129

D 82680

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 501 Burgundy St., 22 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Eutracia Davis

(a) Residence No.... 501 Burgundy St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Jeremiah Davis

6-DATE OF BIRTH (month, day and year) Mar. 22 1875

7-AGE, 48 yrs. — mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) — 041

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm. Lamman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Maria Clemens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Jeremiah Davis

(Address) 501 Burgundy alley

15- Filed JAN 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 11 '24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1923 to Jany 11, 1924 that I last saw h[illegible] alive on Jany 10, 1924 and that death occurred, on the date stated above, at 4.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) [illegible] M. D.

, 1924 (Address) 1116 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn C. DATE OF BURIAL, Jan 14, 1924

20-UNDERTAKER, J. L. Brown & Son ADDRESS 108 W. Monto St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 32681

90 D 32681

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 William St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Baer.

(a) RESIDENCE No 1106 William St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced
(or) WIFE of Charles H. Baer.

6 DATE OF BIRTH (month, day, and year) June 28, 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Philip Ott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Speck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Ott. (son)
(Address) 464 S. Cross St.

15 Filed JAN 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto McRembrandt, M. D.
(Coroner.)

Jan, 11, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL Jan 14 1923

20 UNDERTAKER F. A. Krause & Son — ADDRESS 733 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

82682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1237 E. Biddle ST., 10 (WARD)

2-FULL NAME William A. King

(a) RESIDENCE NO. 1237 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mr. Dora L. King.

6 DATE OF BIRTH (month, day, and year) Dec. 20 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George L. King

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Meyer

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Mrs Dora L. King.
(Address) 1237 E. Biddle

15 FILED JAN 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923, to Jan 12, 1924.

that I last saw h[illegible] alive on Jan 11, 1924,

and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Cardiac dilatation.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

Mitral insufficiency (duration) 2 yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. A. Wright, M. D.

1/12 1924 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan. 15 1924
20 UNDERTAKER Henry Hoerle Son	ADDRESS 1301 E Eager St

N. B.—WHITE PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history

Spec.—1-10-21—M&T—1500 Blks.

D 82683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 135 D 82683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 9 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Lang

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? 52 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman &c

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John E. Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER K. A. Sewald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. N. P. Lang
(Address) Catonsville Md

15 Filed JAN 4 1924 ROBERT R. KRAUTER Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-13 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-24 1923 to 1-13 1923

that I last saw h.[illegible] alive on 1-13 1923

and that death occurred, on the date stated above, at 3 00 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7/24/23 and 1/22/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) I. Norwood Brosius, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer M. E. Church Cemetery Md.	Jan. 15, 1924
20 UNDERTAKER Henry Worell Son	ADDRESS 1301 E Eager St

NOTE—IF ENTRIES ARE MADE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BOOK OAK

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Prostatic Hypertrophy

82684

HEALTH DEPARTMENT—CITY OF BALTIMORE

1651 D 82684

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Druid Hill Park St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludwig Gruber

(Residence in Baltimore: No. 1025 Somerset St 35 St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Aug. (Month) 15 (Day) 1864 (Year)

7-AGE, 59 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER, (State or Country) Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER, (State or Country) Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Katherine Gruber

(Address) 1025 Somerset St

JAN 14 1924

ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Poisoned by Carbolic Acid Suicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Morrison M. D.
(Coroner.)

Jan 14 1924 (Address) 632 Rolandeau

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Jan. 16 1924

20-UNDERTAKER, Henry Hoch Son — ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Erker.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82685

CERTIFICATE OF DEATH.

185

D 82685

1-PLACE OF DEATH University Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Erker

(a) RESIDENCE NO. 641. S. Lakewood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

THIS STATEMENT RECORDS EVERY ITEM OF INFORMATION WITH UNABRIDGING EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WHITE PAPER ONLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Henry B. Erker

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 72 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Univ. Hospital Records

15 Filed JAN 14 1924 ROBERT N. KRAMER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12th 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1924, to Jan 12th, 1924,

that I last saw h[illegible] alive on Jan 12th, 1924,

and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Concussion

Fac. Humerus

Fac. Ex Ends malleolus.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home poss

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John M. Edmonds, M. D.

. 19 (Address) Emergency Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: Jan 15 19 4

20 UNDERTAKER: Peter Nicolaus — ADDRESS: 2060 Eastern

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall down Cellar steps.

Spec.—1-10-21—M&T—1500 Blks.

D 82686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82686

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Holter

(a) RESIDENCE NO. 3410 Old York Rd. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E Holter

6 DATE OF BIRTH (month, day, and year) July 14, 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Holter

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant ..... (Address) Hospital Record.

JAN 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/24 19

17

I HEREBY CERTIFY, That I attended deceased from 12/6/24, 19..., to 1/13/24, 19...

that I last saw h... alive on 1/13/24, 19...

and that death occurred, on the date stated above, at 2.30a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis -
Mitral Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Gangrene
Hypostatic Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holter, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Marie Dawson

DATE OF BURIAL 1/16 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E... North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bkt.

D 82687

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 82687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 827 Ostend 21 Registered No.....

City of BALTIMORE: (No. 827 Ostend St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor K. Owens

(a) Residence No. 827 Ostend St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, Blk | 5-Single, Married, Widowed, or DIVORCED, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 26 1923

7-AGE. 7 yrs. 16 mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Byrd Owens.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Emma Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14- (Informant) Wm C Owens. (Address) 827 Ostend

15- JAN 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 8. 1924 to Jan 11- 1924 that I last saw h[illegible] alive on Jan 10 1924 and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? None Date

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) John G Schwarzburg M. D.

. 19 (Address) 1126 W Lexington St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL, Jan 16 1924

20-UNDERTAKER. Joseph A Farrell | ADDRESS 2314 Druid Hill Ave

All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 82688

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82688

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 102 E Montgomery St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander H. Hart

(a) Residence No. 102 E Montgomery St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sallie A. Hart

6-DATE OF BIRTH (month, day and year): Jan 3 1843

7-AGE: 81 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Employee of United Railroads

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Cecil Co Md

PARENTS:

10-NAME OF FATHER: Robert Hart

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Cecil Co Md

12-MAIDEN NAME OF MOTHER: Julia Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Cecil Co Md

11- (Informant): Sallie A Hart

(Address): 102 E. Montgomery

15- JAN 14 1924

12- ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 11 '24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 2nd 1916 to Jan 11 1924

that I last saw him alive on Jan 11 1924

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. P. Buxton M. D.

1/12, 1924 (Address) 301 East Cross St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER: John F Denny — ADDRESS 715 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 +161-001 D 82689

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, WARD) 7

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Noel

(a) RESIDENCE No 207 E. E St. Sparrows Point, Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. few hours ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan. 11/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		19-hours		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Sparrows Pt. Md

PARENTS

10 NAME OF FATHER Leo. P. Noel

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Oxford, Pa.

12 MAIDEN NAME OF MOTHER Ada E. Westbrook

13 BIRTHPLACE OF MOTHER (city or town) Steelton (State or country) Pa.

14 Informant Leo P. Noel
(Address) 207 E. E St. Sparrow Pt. Md

15 FILED JAN 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity - 7 months gestation

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. T. Parker, M. D. (Coroner)

Jan 13/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Jan 14 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82690 — 103 — D 82690

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 W Fayette St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pernelia Ann Kenwright

(Residence in Baltimore: No. 807 W Fayette St.; 86 yrs., 5 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 26 (Day), 1837 (Year)

7-AGE, 86 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph Logan

11-BIRTHPLACE OF FATHER (State or Country), America

12-MAIDEN NAME OF MOTHER Mary Powel

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Julia M. Muller (daughter)

(Address) 86 W. Fayette St

15- JAN 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 10 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1923, to Jan 10 1924, that I saw h[er] alive on Jan 10 1924, and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows:

Senility

(Terminal) Hypostatic Pneumonia

(Duration)....1 yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration)....yrs.....mos. 3 ds.

(Signed) Joseph C. Richardson M. D.

Jan 14, 1924 (Address) 847 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, January 14, 1924

20-UNDERTAKER J. BOWEN COMPANY

ADDRESS 108 W. NORTH AVE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Crowley

D 82691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82691

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Hattie Crowley

(Residence in Baltimore: No. 614 Fayette St. St.; 8 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	Married

6-DATE OF BIRTH.

..... (Month) ..... 1 ..... (Day) ..... (Year)

7-AGE.	If LESS than 1 day,
38 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Connor McCauley

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Julia Brooks

13-BIRTHPLACE OF MOTHER. (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nannie Brown

(Address) 1924 Mc Culloh St.

JAN 4 1924 Filed ..... 192.....

ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry) find that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in Spine

June 22 1923 to June 10 1924
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shot by C. Dugas as above

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Friedrich M. D.
(Coroner.)

1-13 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 8 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Glen Burnie Va. DATE OF BURIAL, Jan 14 1924

20-UNDERTAKER, Jas A Dennis ADDRESS 1303 Presstman St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

REGISTERED NO. 74-02

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Rosenstein

(a) RESIDENCE NO. 1110 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 21 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard Rosenstein

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 68 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Meyer Laff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Shana —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Louis 1439 Eutaw St

JAN 14 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1923, to Jan. 13, 1924, that I last saw h alive on Jan. 13, 1924, and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension, cerebral thro

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab

(Signed) Isidore H. Fine, M. D.

Jan 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrem Southern — DATE OF BURIAL: Jan 14 1924

20 UNDERTAKER: Jack Louis — ADDRESS: 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH CREASING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

32693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 E Lee St ST.; 7 WARD)

REGISTERED NO. 159 1002 B 82693

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Siemek

(a) RESIDENCE. No. 201 E Lee St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 12-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Siemek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Kulig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Siemek
(Address) 201 E Lee St

15 JAN 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924, to Jan 14, 1924; that I last saw h[illegible] alive on Jan 14, 1924, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Failure of Closing of Foramen Ovale (Blue Baby)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Ashenhurst M. D.

Jan 14 1924 (Address) 114 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Jan 14 1924

20 UNDERTAKER Jacob Pinkenovitz ADDRESS 1132 S. Bond St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82694

CERTIFICATE OF DEATH.

82694

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 W. Fairmount Ave. St. 20 Ward)

2-FULL NAME Donald Veasel

(a) RESIDENCE. No. 1923 W. Fairmount Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER George Veasel

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wrynn

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant George Veasel
(Address) 1923 W. Fairmount Ave.

15 Filed JAN 14 1924 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 11, 1924, that I last saw him alive on Jan 11, 1924, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchs - pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo. L. Wisig, M. D.

1-14 1924 (Address) 1500 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 14 1924
20 UNDERTAKER Joseph L. Cook	ADDRESS 1003 N. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82695

CERTIFICATE OF DEATH.

90 D 82695

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1926 Lemon Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Baptist Ridgeway

(a) Residence No. 1926 Lemon Street St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura V. Ridgeway

6-DATE OF BIRTH (month, day and year)

7-AGE: 66 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Brick Maker

(c) Name of employer:

9-BIRTHPLACE (city or town): Philadelphia (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, John Ridgeway

11-BIRTHPLACE OF FATHER (city or town) (State or Country), United States

12-MAIDEN NAME OF MOTHER, Eleanor Koontz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), France

14- (Informant) Mrs. George Donaldson

(Address) 1926 Lemon St.

15- JAN 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923 to Jan 12, 1924

that I last saw h— alive on Jan 11, 1924

and that death occurred, on the date stated above, at 9.30 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(Duration) yrs. 1 mos. 11 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1-12. 1924 (Address) 1729 W. Lombard St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cem	Jan 14, 1924
20-UNDERTAKER. Joseph L. Cook	ADDRESS 1003 W. Pratt St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165 D 82696 Pet

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 86 -001

D 82696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

2-FULL NAME Anne Krikun

(a) RESIDENCE NO. Point of Rocks Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12 1923

7 AGE — Years: X — Months: 6 — Days: 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 JAN 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14. 1924

17

I HEREBY CERTIFY, That I attended deceased from July 25. 1923, to Jan 14. 1924

that I last saw h.. alive on Jan 14. 1924,

and that death occurred, on the date stated above, at 1 30 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

Obstetrics (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Cooper Folkoff, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md. — DATE OF BURIAL: Jan 14 1923

20 UNDERTAKER: Jos B Cook — ADDRESS: 1003 W Balto St.

INFORMATION, WITH CERTIFICATE.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82697

CERTIFICATE OF DEATH.

100-801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 E. 21st ST., 9 WARD)

2-FULL NAME John Judson Curley

(a) RESIDENCE NO. 733 E. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of) Cora E. Curley nee Chenoweths

6 DATE OF BIRTH (month, day, and year) August 26 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	5	14	

[Hospital]

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Asst. Treas. Johns Hopkins

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Johns Hopkins Hospital

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Duncan Curley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Shepherdstown
(State or country) Va.

14

Informant Helen Curley Tingley

(Address) 733 E. 21st Street.

15

JAN 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1924

17

I HEREBY CERTIFY, That I attended deceased from January 8, 1924, to January 12, 1924, that I last saw him alive on January 12, 1924, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Streptococcus Hemolyticus)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Blue Ridge Summit

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood and Sputum Cultures

(Signed) Samuel Solomon, M. D.

, 19 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 15 1924
20 UNDERTAKER	ADDRESS
John B Spence	1325 N. Eutaw St

N. B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—150) B[illegible].

D 82698.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D. 82698

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1430 Presstman ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas S. Simms.

(a) RESIDENCE NO. 1430 Presstman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Hammond.

6 DATE OF BIRTH (month, day, and year) Sept 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) O'T

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lewis Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Alton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Jane Grays

(Address) 1430 Presstman St

15 Filed ..... 19 .....

JAN 14 1924

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 27th, 1923, to Jan 11th, 1924.

that I last saw him alive on Jan 8, 1924

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis of Heart

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

1924 (Address) 1430 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 17 1924

20 UNDERTAKER Jos A Farrell ADDRESS 2319 Lemmon St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82699

CERTIFICATE OF DEATH.

101-001 D 82699

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1828 Bank ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Beyer.

(a) RESIDENCE No. 1828 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27th 1915

7 AGE — Years: 8 — Months: 8 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School attendant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Ods

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Beyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Elizabeth Pentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: John Beyer (Address): 1828 Robert A. Krauter

15 Filed JAN 4 1924 Robert A. Krauter, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 5th, 1924, to Jany 10th, 1924, that I last saw her alive on Jany 10th 1924, and that death occurred, on the date stated above, at 10 55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb R. Peacock, M. D.

Jan 11 1924 (Address) 100 E. Pollerton Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem — DATE OF BURIAL: Jan 14 1924

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 1003 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82700

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH Union Memorial Hospital.

CITY OF BALTIMORE: (No. 33rd + Calvert Sts. ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Stein.

(a) RESIDENCE NO. 420 South Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Elmer Stein.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Illinois

12 MAIDEN NAME OF MOTHER: Marie Bender.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Elmer Stein

(Address) 420 S. Stricker St.

15 JAN 14 1924 ROBERT R. KRAUTER, Registrar

Asst. Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1924. to Jan. 11, 1924.

that I last saw him alive on Jan 11, 1924.

and that death occurred, on the date stated above, at 8.05 A. m.

The CAUSE OF DEATH* was as follows:

Accidental Burns.

O. K. Conner J. J. Morrissey

(duration) 0 yrs. 0 mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 420 South Stricker St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A.B. Price, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	1/14 24

20 UNDERTAKER: A. H. Wyke ADDRESS 531 W. Lombard

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningcs, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Playing with Matches

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82701

CERTIFICATE OF DEATH.

16-001

D 82701

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 E Cross St.: 24 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Elias O'Keefe

(a) RESIDENCE. No. 207 E Cross St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Ernest O'Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Wallenta Guentrotte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Ernest O'Keefe 207 E Cross St

15 [illegible]

JAN 14 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 14, 1924, that I last saw him alive on Jan 14, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Premature birth
6 mos gestation

.....(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M L Brighton, M. D.

1/14, 1924 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a a Co	1-14 1924
20 UNDERTAKER	ADDRESS
Ed B Harle	115 E West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82702

CERTIFICATE OF DEATH.

101-001 D 82702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2054 Kennedy Ave. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Bell

(a) RESIDENCE NO. 2054 Kennedy Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----p

6 DATE OF BIRTH (month, day, and year) Sep. 22. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) catalog division

(c) Name of employer C.&.P.Telephone Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Josiah V.Bell

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cornelia Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.

(State or country) Maryland

14 Informant Wm.F.Flowers

(Address) 2054 Kennedy Ave.

15 JAN 4 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.12.1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Jan 12, 1924, that I last saw h[illegible] alive on Jan 12, 1924 and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Right side of Apartment 6th

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? M Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) Henry Hughes, M. D.

, 19 (Address) 1100 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1-15-24 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 82703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82703

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 N. Fulton Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Dora L. Ritter

(Residence in Baltimore: No. Home for the Aged of the U.E Church St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, May (Month) 25 (Day), 1836 (Year)

7-AGE, 87 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Philip Wagner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Ambel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Buddy

(Address) 400 N. Fulton Ave

15-Filed JAN 14 1924, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 13 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 2 1923, to January 13 1924, that I saw her alive on January 16 1924, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows: See back.

Chronic Nephritis

(Duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ✓ yrs. ✓ mos. 3 ds.

(Signed) George C. Shannon M. D.

1/14, 1924 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, Jan 15, 1924

20-UNDERTAKER George J. Smith — ADDRESS 1532 Hollins st

I.S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82704

CERTIFICATE OF DEATH.

2 74-001

D 82704

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2052 Bank St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthonette Gajewski

(a) Residence No. 2052 Bank St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE: Michael Gajewski

6-DATE OF BIRTH (month, day and year): Nov. 20 18 [illegible]

7-AGE: 69 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Do not Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Do not Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Walter Gajewski

(Address) 3 N. Ellwood Ave

JAN 4 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1924 to Jan. 12, 1924

that I last saw h.. alive on Jan 11 1924

and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

2

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. P. Neer, M. D.

1/13/24 (Address) 408 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Pleasant

DATE OF BURIAL, Jan 15 19 24

20-UNDERTAKER: A. A. Gajewski

ADDRESS 2350 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 82705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82705

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Childrens Hospital school St., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Taylor

(Residence in Baltimore: No. childrens Hospital School St.; 1 yrs., 10 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, March 1 (Month) (Day) 1911 (Year)

7-AGE, 12 yrs. 10 mos. 13 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School-boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin David Weinberg M.D.

(Address) Childrens Hosp. School

15- Dec. ....., 191.....

JAN 14 1924

Robert P. Harrison, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13th, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1st 1923, to January 13th 1924, that I saw him alive on January 12th 1924, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Osteomyelitis multiple

(Duration) 21 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 7 yrs. 2 mos. ..... ds.

(Signed) Edwin David Weinberg M. D.

Jan. 13, 1924 (Address) Childrens Hosp. School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 10 mos. ..... ds. In the State 12 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Centreville Md.

Former or usual residence Centreville Md.

19-PLACE OF BURIAL OR REMOVAL: Baltimore — DATE OF BURIAL, Jan. 17, 1924

20-UNDERTAKER: Wm Curtis & Son — ADDRESS Elkton

NOTICE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1238 N Fawsale St St., 16 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margrete Leporte

(a) Residence No. 1238 N Fawsale St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) April 4 1855

7-AGE. 68 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER, Kinert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Nadie C. McDowell

(Address) 1238 N. Fawsale St

15-

Filed ..... 1924 Robert P. Harrison, Registrar.

JAN 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 13-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924 to Jan 13, 1924

that I last saw h.. alive on Jan 13, 1924

and that death occurred, on the date stated above, at 1030P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ....yrs. 2 mos.....ds.

CONTRIBUTORY (Secondary) General Anaemia

(Duration) ....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A Morgan M. D.

, 19 (Address) 1322 Hartman

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, Jan 15 1924

20-UNDERTAKER. Wm Cook

ADDRESS 501 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 82707 / 16 4287 C

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 D 82707

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Junior Johnson

(a) RESIDENCE No. 708 Tyson St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 5 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov 28, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	1	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... "

(c) Name of employer ..... "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Junior

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Ida Reidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant ..... (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 Robert P. Harrison, Registrar

JAN 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Jan 9, 1924, that I last saw him alive on Jan 9, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

Acute Miliary Tuberculosis

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bragg, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 12 1924

20 UNDERTAKER ..... ADDRESS .....

Commissioner Health,

E. WOODALL

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. E... of information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. Municipal Hospital St., No Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Michael Norowski

(a) Residence No. Woodland Ave., Turners Station. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1863

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Municipal Hospital Records

(Address) HOPKINS

15- Dec Jan 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 10 1923 to January 10 1924

that I last saw h.. im alive on January 10 1924

and that death occurred, on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

Complete Laceration of Trachea - with subsequent formation of tracheal fistula

Suicidal. (Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 10, 23

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Faulton, M. D

1-11-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	JAN 12 1924
20-UNDERTAKER.	ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82709

CERTIFICATE OF DEATH.

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Old Pimlico Rd ST., Osweg 15 WARD)

2-FULL NAME Louis T. Weis

(a) RESIDENCE NO. Old Pimlico Rd ST., Osweg 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret C. Weis

6 DATE OF BIRTH (month, day, and year) Aug. 25 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.S. Printing Ink Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Vice Pres &

(c) Name of employer Retired Baltimore

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant M. Albert N. Weis

(Address) 401 Park Heights Ave

15 Filed JAN 14 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12. 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept, 19 21, to Jany 12 19 24

that I last saw him alive on Jany 11, 19 24,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Chronic Nephritis — several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F F Kirby, M. D.

1/14, 19 24 (Address) 1156 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan 15, 24
20 UNDERTAKER	ADDRESS
Wm J Peeples & Son	Morley Pa

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. Information should be stated EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82710

CERTIFICATE OF DEATH.

161-001 ✓ D 82710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3641 Belair ave ST. (13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Joyce

(a) RESIDENCE NO. 3641 Belair ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11 1924

7 AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) 3641 Belair ave
(State or country)

PARENTS

10 NAME OF FATHER Harold Joyce

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Anna Caroline Young

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Crisfield Md

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 14 1924, 19 .....
Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Jan 11, 1924.

that I last saw him alive on Jan 11, 1924.

and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Premature births

6 Months Pregnancy
(duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. Mitchell Darby, M. D.

. 19 (Address) 3621 Dalrymple Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: JAN 14 1924

20 UNDERTAKER: Commissioner Health — ADDRESS .....

JAN 14 1924

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-60 D 82711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 S. East ave ST.: 7th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Burnes

(a) RESIDENCE. No. 1113 S. East ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-11-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hrs. / min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Burnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Alice Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Robert Burnes (Address) 1113 S. East ave.

15 Filed JAN 14 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-11-1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1924 to Jan. 11, 1924, that I last saw him alive on Jan 11, 1924 and that death occurred, on the date stated above, at 6:05 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity at 6 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromsular, M. D.

1-12-1924 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: JAN 14 1924

20 UNDERTAKER — ADDRESS

Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82712

HEALTH DEPARTMENT—CITY OF BALTIMORE

H Potter

185 D 82712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred B. Hodges.

(a) RESIDENCE NO 2608 Foster Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Hodges

6 DATE OF BIRTH (month, day, and year) April 16-1852.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8.	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer General

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Edwin Lee Hodges
(Address) 2608 Foster Ave

15 Filed ... 192 Robert P. Harrison, Registrar.

JAN 14 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Fractured leg-accidental fell in street (duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Dolan, M. D.
(Coroner.)

Jan 14/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., 5 ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
Fell in Street

Former or usual residence 2608 Foster Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 1-15 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.–400 Blks.

TREGOR

D 82713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82713

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 518 Rossiter Av St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie K. Tregor

(a) Residence No. 518 Rossiter Av St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James A

6-DATE OF BIRTH (month, day and year) Feb 27 1867

7-AGE. 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ill.

PARENTS.

10-NAME OF FATHER, William Loveless

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Mary Harrington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ill.

14- (Informant) Mrs Ida E Marshall

(Address) 518 Rossiter Av

15- JAN 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 13 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to January 13 1927 that I last saw h[illegible] alive on Jan 13 1927 and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Chronic Interstitial Nephritis 6 yrs

Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) B. F. Bishop M. D

Jan 13 1924 (Address) 501 Cheselden Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Jan 15 1924

DATE OF BURIAL,

20-UNDERTAKER: Wm Cook

ADDRESS: 50 E Lan Av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82714

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 82714

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3621 Falls Rd ST.: ... WARD) 19

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Foriegn

(Residence in Baltimore: No. 3621 Falls Road St.: 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: March 14, 1867 (Month) (Day) (Year)

7 AGE: 56 yrs. 9 mos. 29 ds. | If LESS than 1 day, ... hrs. or .... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): St. Paul, Minn.

PARENTS

10 NAME OF FATHER: Robt. L. Foriegn

11 BIRTHPLACE OF FATHER (State or country): Irelandy

12 MAIDEN NAME OF MOTHER: E. Marie Towers

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jm. F. Ryan

(Address) 3621 Falls Road

15 Robert P. Harrison, ... 191 Registrar
Burial Permit Clerk.

N 1 41924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 12 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923 to. Jany 12 1924
that I saw h— alive on Jany 12 1924
and that death occurred, on the date stated above, at 5.40 a.m.
The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease

(Duration) .... yrs. 2 mos. 0 ds

Contributory (SECONDARY) Arterio Sclerosis Hemiplegia

(Duration) .... yrs. .... mos. 2 ds.

(Signed) H. L. Powers M. D.

1/12, 1924 (Address) 921 N Chas.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. | In the State .... yrs. .... mos. .... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: E. Mayo Towers | DATE OF BURIAL: Jan. 15 1924

20 UNDERTAKER: Horace F. Burgee | ADDRESS: 3631 Falls Road.

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and others may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A.K. S.A.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82715

CERTIFICATE OF DEATH.

60-09 ✓ D 82715

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 10 WARD)

2-FULL NAME Mrs. Mary E. McNamara

(a) RESIDENCE NO. 844 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE: Years 48; Months 9; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balt md

(State or country)

PARENTS

10 NAME OF FATHER Peter McNamara

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Monaghan

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Hospital Record

(Address)

15 JAN 14 1924, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/24

17

I HEREBY CERTIFY, That I attended deceased from 12/1/23, 19 . to 1/12/24, 19 .

that I last saw h[illegible] alive on 1/12/24, 19 ,

and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Lupus erythematosus of thyroid.

(duration) 6 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Leprosy

(duration) 6 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Glyndebourne

Did an operation precede death? yes Date of 4/11/24

Was there an autopsy? no

What test confirmed diagnosis? Signs & Operation

(Signed) A. W. Dalbey, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Jan. 15 1924

20 UNDERTAKER: H. C. Wedefield — ADDRESS: 914 Greenmt Ave

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exophthalmic Goiter

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore and Payson Sts. 101-001 REGISTERED NO.....

CITY OF BALTIMORE, (No. German Aged Home ST. 110 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Knab.

(a) RESIDENCE. No. German Aged Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Knab.

6 DATE OF BIRTH (month, day, and year) Sept 27 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Knab.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Herpunder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant German Aged Home Record
(Address) Balto and Payson Sts

15 Filed ..... 19.. Robert F. ...
Registrar

JAN 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/24. 19

17

I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1924, to Jan 13, 1924, that I last saw her alive on Jan 13th, 1924, and that death occurred, on the date stated above, at 2.20P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Old Age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John Houff, M. D.

. 19 (Address) 1843 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loretto	Jan 15 24 19
20 UNDERTAKER	ADDRESS
Leo B. Otto	1003 N Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82717

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 82717

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2529 W. Fayette Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Stimmel

(a) Residence No. 2529 W. Fayette Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Artiemitie Stimmel

6-DATE OF BIRTH (month, day and year) 1847

7-AGE. 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Mr. Stimmel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) W. M. Stimmel

(Address) 4141 Park Heights Ave.

15- Filed Robert F. Harrison, Registrar.

JAN 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 19 23 to Jan 13 19 23

that I last saw h[illegible] alive on Jan 12 19 23

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arteri-Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (2 weeks)

Hypostatic Pneumonia (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Dunn M. D.

1-15, 19 24 (Address) 801 N. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Jan 15, 19 24
Winchester Va	
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 82718

HEALTH DEPARTMENT—CITY OF BALTIMORE

73 D 82718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 332 N. Hilton Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Belle Weber

(a) Residence No. 332 N. Hilton St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: William A. Weber

6-DATE OF BIRTH (month, day and year): Jan. 10, 1865

7-AGE: 59 yrs. — mos. 2 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Bloomfield County, Kentucky

PARENTS.

10-NAME OF FATHER: Francis D. Banks

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Artha Roland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14-

(Informant): John B. Forrest

(Address): 332 N. Hilton St.

15-

Filed JAN 14 1924, 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920 to Jan. 11, 1924

that I last saw h. W. alive on Jan. 11, 1924

and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans
(Parkin's Disease)
(Duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis
(Duration) 1 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

1-15, 1924 (Address) 15 W. Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan. 16, 1924

20-UNDERTAKER: Joseph B. Cook — ADDRESS: 1023 W Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82719 ✓ D 82719

CERTIFICATE OF DEATH.

X 170

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hotel Plaza St., 11 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Navarro.

(a) RESIDENCE No. Sykesville Md ST., ... WARD Sykesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? 5 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Attendant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sykesville Hosp.

9 BIRTHPLACE (city or town) (State or country) Ecuador S.A.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant [illegible] Police Dept.
(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

JAN 14 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in brain

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] (Coroner), M. D.

Jan 14, 1924 (Address) 1634 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield Cemetery Carroll Co. Md	1/15 1924
20 UNDERTAKER James R. Weer	ADDRESS Sykesville Md

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82720

CERTIFICATE OF DEATH.

188-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert D Thd

(Residence in Baltimore: No. 838 N Eutaw St 30 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Sgle

6-DATE OF BIRTH. ..... Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Benj Otho

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Jackson

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Wilson

(Address) 838 N Eutaw St

15- Filed JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan. (Month) 14 (Day), 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) ..... yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Struck by Mule S.R.R. Car

(Duration) ..... yrs. 1 mos. 3 ds.

(Signed) M. K. Gonsal M. D. (Coroner.)

1-14 192 4 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn et — DATE OF BURIAL. Jan 16 1924

20-UNDERTAKER. L. V. Brown & Son — ADDRESS 108 N. Mont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82721

CERTIFICATE OF DEATH.

38 D 82721

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Andrew Wallace

(a) Residence No. 822 Sharp St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1869

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER, John Wallace

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Campbell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from November 22, 19 23 to January 12, 19 24

that I last saw h. im alive on January 11 19 24

and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic Aortitis

Aortic Insufficiency

(Duration) yrs. 8 mos. (history) ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Drane M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Auburn	Jan 16 1924
20-UNDERTAKER,	**ADDRESS**
W. L. V. Brown & Son	1081 Monroe

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82722

CERTIFICATE OF DEATH.

94-901 ✓ D 82722

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 100 N. Milton Ave ST., 6 WARD)

2-FULL NAME Annie E. Foxwell

(a) RESIDENCE NO. 100 N. Milton ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George W. Foxwell

6 DATE OF BIRTH (month, day, and year): Dec 20th 1856

7 AGE: Years 67 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George W. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah E. Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: George W. Foxwell. (Address) 100 N. Milton ave

15 Filed JAN 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 12, 1924, that I last saw h[illegible] alive on Jan 11, 1924, and that death occurred, on the date stated above, at 3 20/a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Exhaustion.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Diagnosis

(Signed) Adolph C. Eisenberg, M. D.

Jan 15 1924 (Address) 220 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Jan 16th 1924

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82723

CERTIFICATE OF DEATH.

38 D 82723

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 Bradley ST., 17 WARD)

2-FULL NAME John Ross

(a) RESIDENCE NO. 834 Bradley ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dead

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Lenard Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Linch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James H. Ross

(Address) 836 Bradley

15 JAN 5 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-18-23, to 1-11-24, that I last saw h alive on 1-11-24, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypovitality, Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. H. Cardozo, M. D.

(Address) 1524 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 19 24

20 UNDERTAKER MacMahon & Jones ADDRESS 1711 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Blks.

D 82724

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82724

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 649 W. Lee ST. 22 WARD)

2-FULL NAME Sarah Scott

(a) RESIDENCE NO. 649 W. Lee ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Norfolk, Va
(State or country)

PARENTS

10 NAME OF FATHER George Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norfolk, Va

12 MAIDEN NAME OF MOTHER Leah Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bellhaven, Va

14 Informant Leah Scott
(Address) 649 W. Lee St

15 JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to January 13, 1924, that I last saw ~~him~~ alive on January 12, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. O. Smith M. D.

, 19 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Jan 16 1923
20 UNDERTAKER	ADDRESS
John H. Joachim	Ostend St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 82725

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-09 82725

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Kwedar Sr

(a) RESIDENCE No. 2409 Christiann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 16/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	✓	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Kwedar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Bernotas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William Kwedar
(Address) 2409 Christiann St

15 JAN 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan13/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. A. Fallis, M. D. (Coroner.)

Jan 14/24 (Address) 606 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Janv. 16. 1924
20 UNDERTAKER	ADDRESS
John Grebliauckas J. G.	425 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82726

CERTIFICATE OF DEATH.

179 D 82726

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harriet Washington

(a) RESIDENCE NO 1419 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9yr yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melvin Washington

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60 Y9			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Formally 070
(b) General nature of industry, business, or establishment in which employed (or employer) Housemaid
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mose Howard (son) (Address) 1419 N. Brice St

15 JAN 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Burnson Abd., buttocks, back, thighs & arms.
Accidental-clothing caught fire from Stove, Jan 8th., /24 at ..... mos ..... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Wooden (Coroner.), M. D.

Jan 14/24 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 15 1924

20 UNDERTAKER Joseph A Farrell — ADDRESS 2319 Druid

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82727

CERTIFICATE OF DEATH.

46 D 82727

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2795 Alameda Blvd ST., 9 WARD)

2-FULL NAME Margaret a. Glen

(a) RESIDENCE No. 2795 Alameda Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 15th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER James Glen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Janet Cherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs A Powell (Address) 416 Calvert ave

15 Filed JAN 5 1927 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 1927

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1923, to Jan 13 1927.

that I last saw her alive on Jan 12 1927

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cancer

(Epithelioma of the vagina)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of April 1923

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Leo L. Zimmerman, M. D.

1/13. 1927 (Address) 2858 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 16th 1927

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 Monument

Spec.—1-10-21—M&T—1500 Blks.

16864S Med 82728

HEALTH DEPARTMENT—CITY OF BALTIMORE

82728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 + 47 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Blake

(a) RESIDENCE NO. 314 Penn Ave - Towson ST., Md WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John W. Blake

6 DATE OF BIRTH (month, day, and year) ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Winston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923, to Jan 14, 1924, that I last saw h— alive on Jan 14, 1924, and that death occurred, on the date stated above, at 1.55 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma origin breast—

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Metastases to Lungs

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of June 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) T. R. Hannon M. D.

1/14, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill Cemetery DATE OF BURIAL 1-17 1924

20 UNDERTAKER George T. A. Gibson ADDRESS 1631 Lewis Hilton Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82729

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Hospital for the Women of Maryland. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Caroline Sides Merryman

(a) RESIDENCE NO. 235 N. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Wesley M. Merryman

6 DATE OF BIRTH (month, day, and year): Sept. 7 1850

7 AGE: Years 73 | Months 4 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: William G. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll County, Md.

12 MAIDEN NAME OF MOTHER: Mary A. Sides

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard County, Md.

14 Informant: Miss Fannie Brown
(Address): 235 N. Calhoun St

15 JAN 15 1924 ROBERT R. KRAUTER
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Jan 14, 1924, that I last saw her alive on Jan 14, 1924, and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

~~Pulmonary Congestion~~
Acute Pulmonary Oedema

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) [illegible] M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem | DATE OF BURIAL: Jan 15 1924

20 UNDERTAKER: Chas. O. Mitchell | ADDRESS: 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Myocarditis

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82730

CERTIFICATE OF DEATH.

174 ✓ D 82730

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lola M. Elliott.

(a) RESIDENCE NO. 1011 Riverside Ave. ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 6. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) March 8, 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Candy packer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: William Elliott.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Bertha Catton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Marys Co. Md.

14 Informant: William Elliott. (father)
(Address): 1011 Riverside Ave.

15 JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Traumatic Pneumonia.
Accidental burns about the body.
from a gas oven.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)
Jan. 14, 192 4 (Address) 10.17 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident at 1011 Riverside Ave. Dec. 26. 1923

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 15 1924

20 UNDERTAKER: A. Howard Evans ADDRESS: 1428 E. Chas St

Spec.—2-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82731

CERTIFICATE OF DEATH.

D 82731

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Earl Heuer (Heuer)

(a) RESIDENCE NO. 911 Jefferson St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Heuer

6 DATE OF BIRTH (month, day, and year) Oct 25 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 086

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer #27

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 12, 1924, that I last saw him alive on Jan 12, 1924, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan 12 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J. L. Resident, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 1/16 1924

20 UNDERTAKER Philip Henry — ADDRESS 206 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82732

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 82732

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 951 Brooks Lane St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Louis Federlicht

(a) Residence No. 951 Brooks Lane Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

Single, Married, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hortense Federlicht

6-DATE OF BIRTH (month, day and year) Dec. 2, 1848

7-AGE. 75 yrs. 1 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Ret. Woolen

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.
(State or Country)..... Md.

PARENTS.

10-NAME OF FATHER Abraham Federlicht

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Germany

12-MAIDEN NAME OF MOTHER Rosa Plaut

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Germany

14- (Informant) David Federlicht

(Address) 951 Brooks Lane

15- Filed JAN 15 1924 GILBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-13-24.

17- I HEREBY CERTIFY, That I attended deceased from Jan'y 21st 1922 to Jany 13 1924 that I last saw him alive on Jany 13 1924 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris (Coronary artery sclerosis)

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; aortic insuf ficency;

myocarditis.

(Duration) 2 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger M. D

, 19 (Address) 1207 Eutaw Place.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Hebrew Cem. DATE OF BURIAL, 1-15-, 1924.

20-UNDERTAKER. David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Kahn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82733

CERTIFICATE OF DEATH.

1 + 29

D 82733

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1700 Eutaw Place — St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Kahn

(a) Residence No. 1700 Eutaw Place St., Ward Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Kahn

6-DATE OF BIRTH (month, day and year) May 13th 1867

7-AGE. 56 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Advertising

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Wanfried Germany

PARENTS.

10-NAME OF FATHER, Louis Kahn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophie Gutzeit

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Dorothy Kahn

(Address) 1700 Eutaw Place

15- Filed JAN 15 1924 WILLIAM T. R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20th 1923, to Jan. 14 1924

that I last saw h. alive on June 14 1924,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) Eugene Shapard M. D

, 19 (Address) 200 W Lafayette Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL. London Pk. Crematory — DATE OF BURIAL. 1-16-, 1924

20-UNDERTAKER, David Sondheim — ADDRESS 1120 W. Mt. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82734

801

D 82734

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 305 E. 27th. St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Jean Schindler.

(Residence in Baltimore: No. 305 E. 27th. St. St.; yrs., Lifetime mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, ... October 7th., 1923.. (Month) (Day) (Year)

7-AGE, ... yrs. 3 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank A. Schindler

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER Hester D. Lyons

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hester D. Schindler.....

(Address) ..... 305 E. 27th. St. .....

15- Filed JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 14th., 1924. ....., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Convulsions .....

..... (over.)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Jan 15, 1924 (Address) 3632 Roland Avenue.....

(State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery. DATE OF BURIAL, Jan. 15. 19.24

20-UNDERTAKER Chas. R. Evans & Son ADDRESS 1181 W. Mt. Royal Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Scalia

D 82735

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 82735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 36 S Caroll St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank P. Scallio

(a) Residence No. 36 S Caroll St., 18 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 23- 1903

7-AGE. 20 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 945

(b) General nature of industry, business, or establishment in which employed (or employer) Fruit Dealer

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Santo Scallio

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Maria Balsamo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) M Balsamo

(Address) 36 S Caroll St

15- JAN 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/14/24

17- I HEREBY CERTIFY, That I attended deceased from 8/27/23, 19..., to 1/14/23, 19..., that I last saw h[illegible] alive on 1/13/23, 19..., and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insuf

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [illegible] M. D

1/14/24 19 (Address) 1302 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem

DATE OF BURIAL. 1/17, 1924

20-UNDERTAKER, Robert Brookmire

ADDRESS Calhoun & Holliday Sts

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Due to Scarlet Fever
Some yrs. ago.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82736

CERTIFICATE OF DEATH.

Registered No. 54-00W

1-PLACE OF DEATH

City of BALTIMORE: (No. 1713 Cole St St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Maurice G Brocoxley

(a) Residence No. 1713 Cole St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 13 1924

7-AGE. .....yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Maurice G Brocoxley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Mary Hale.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14- (Informant). Mr. Maurice G Brocoxley

(Address) 1713 Cole St

15- JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1924 to Jan 14 1924 that I last saw h alive on Jan 14 1924 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

Remained cyanotic from birth until death.

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart failure due to Patent ovale not closed (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Remained cyanotic

(Signed) Thos H Phillips M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
W M Oliver Loys	Jan 15 1924
20-UNDERTAKER. John B Keeney Sons Inc Per J F Lawn	ADDRESS. York Road

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82737

CERTIFICATE OF DEATH.

D 82737

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Maryland ave St. W WARD)

2-FULL NAME Rex Corbin Spencer Maupin

(a) RESIDENCE NO. 2004 Maryland ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Lewis Maupin

6 DATE OF BIRTH (month, day, and year): Feb. 21-1884

7 AGE: Years 39 Months 10 Days 22 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Ind~~

(b) General nature of industry, business, or establishment in which employed (or employer): Ind Agricultural & Chemic Co

(c) Name of employer: Upsher Hooper

9 BIRTHPLACE (city or town) (State or country): Bedford Co Va

PARENTS

10 NAME OF FATHER: Wm Carey Maupin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charlottsville Va

12 MAIDEN NAME OF MOTHER: Sarah Hatcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bedford Co Va

14 Informant: Mrs Rex Corbin Spencer Maupin
(Address) 2004 Maryland ave

15 JAN 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan-13th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to Jan 13th 1924,
that I last saw h. was alive on Jan 13 1924,
and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Endocarditis

(duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓ Histologic microscopic Exam

(Signed) Robert R. Krauter M. D.

1924 (Address) 1117 Hungerford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Portsmouth Va — DATE OF BURIAL: 1-15-1924

20 UNDERTAKER: Henry W. Jenkins Sons Co — ADDRESS: Richard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infected Teeth
Rheumatism

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

D 82738

CERTIFICATE OF DEATH.

D 82738

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 W Franklin ST., 17 WARD)

2-FULL NAME Mrs Louisa Frederick

(a) RESIDENCE NO. 614 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emerson

6 DATE OF BIRTH (month, day, and year):

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: George Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Gerding

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: George Burgess

(Address): Arlington

15 JAN 15 1924 ROBERT M. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Jan 13, 1924, that I last saw h[illegible] alive on Jan 13, 1924, and that death occurred, on the date stated above, at 10 1/2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary): none

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Symptoms

What test confirmed diagnosis?

(Signed) R B Kenyon, M. D.

1/14, 1924 (Address) 617 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan 16 1924

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks

D 82739

Dekowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

CERTIFICATE OF DEATH.

D 82739

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1722 Aliceanna ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John DeKowski

(a) RESIDENCE NO. 1722 Aliceanna ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary DeKowski

6 DATE OF BIRTH (month, day, and year) Oct 18 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus DeKowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Coratie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael DeKowski

(Address) 705 S. Ann St

15 Filed JAN 15 1924 ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13 1924

17

I HEREBY CERTIFY, That I attended deceased from December 31, 1923 to January 12, 1924

that I last saw him alive on January 12, 1924

and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Natural Causes

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cough

(Signed) M. Dekowski, M. D.

1-14, 1924 (Address) 722 Aliceanna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Brun	Jan. 16" 1924,
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholism

D 82740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82740

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2135 Mc Culloh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Spencer

(Residence in Baltimore: No. 2135 Mc Culloh St. St.) (yrs. 10 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): widow

6-DATE OF BIRTH: about (Month) 1 (Day) 1848 (Year)

7-AGE: 76 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Richard James

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Albina Lee

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Davis

(Address) 2135 Mc Culloh St

15- JAN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 11, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Jan. 12 1924 (Address) 2102 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Jan 13 1924

20-UNDERTAKER, Jas H Dennis — ADDRESS 1303 Pennsylvania Ave

Spec.—1-10-21—M&T—1500 Blks.

D 82741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82741

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Florence May Miller

(a) RESIDENCE NO. Manchester Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Miller

6 DATE OF BIRTH (month, day, and year) June 20 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .min.
	60	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Manchester
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Shaffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Butler

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co.
(State or country) Md.

14 Informant Samuel Miller
(Address) Manchester Md

15 JAN 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Jan 15, 1924, that I last saw her alive on Jan 15, 1924, and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

(duration) 2½ yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan 13-1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) R. J. Plyler, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Md	Jan 19 1924
20 UNDERTAKER	ADDRESS
Jacob Wirth & Son	Manchester

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 82742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

2-FULL NAME William Keil.

(a) RESIDENCE NO. 2117 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
mall	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 15 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Wm. F. Keil

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mina Sollmann

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Williams Keil (Address) 2117 Frederick Ave.

15 JAN 1 5 1924 HOBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 14, 1924, that I last saw him alive on Jan 14, 1924, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar, pharyngeal & laryngeal (duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) myocarditis (duration) — yrs. — mos. 3 d/s.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

1/15/24 Bullagowan M. D. (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan. 15 1924

20 UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82743 X 117 ✓ D 82743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. St Joseph Hosp. St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Eric Johnson

(a) RESIDENCE No. 1203 Longwood Ave WARD Toddrille Dorchest Co Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1875

7 AGE: Years 48 | Months — | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Aaron Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gr. Anna Willey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant O W. McNamara

(Address) Annapolis Md

JAN 5 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11th 1924 to Jan 14 1924 that I last saw him alive on Jan 14th 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrenous Appendix

Localized Peritonitis (duration) yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 11th 1924

Was there an autopsy? No

What test confirmed diagnosis? Oper.

(Signed) A C Manning, M. D.

1-14 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Toddrille Dorchester Co Md — DATE OF BURIAL: Jan 6 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 902 E. Fayette

...WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Phillips, 2300 N. Edmondson Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 09 D 82744

1-PLACE OF DEATH 1914 Ramsay St. 20 Registered No.....

City of BALTIMORE: (No.....St., 20 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Noah J Williams

(a) Residence No. 1914 Ramsay Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Nellie Williams

6-DATE OF BIRTH (month, day and year) Dec 13, 1854

7-AGE. 64 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 06

(c) Name of employer Solomonson Fly Screen

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14-Informant Mrs Ruth Palmore

(Address) 1914 Ramsey St.

15-Filed JAN 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 14. 1924

17-I HEREBY CERTIFY, That I attended deceased from Jan 14 1924 to Jan 14 1924 that I last saw h.. alive on Jan 14 1924 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos H Phillips M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan 17 1924

20-UNDERTAKER, Wm Cook For E Monroe — ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., ... WARD) Municipal Tuberculosis Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. H. (John) Frisby

(a) RESIDENCE NO. Levering House ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Frisby

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Newfoundland

12 MAIDEN NAME OF MOTHER Anna Nent

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address) JOHNS HOPKINS HOSPITAL

15 JAN 15 1924 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1923, to Jan. 12, 1924, that I last saw him alive on Jan. 12, 1924, and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L. A. Lally, M. D.

1-12-1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, ADDRESS .....

JAN 15 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82746

CERTIFICATE OF DEATH.

100-001

D 82746

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gibbons

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE: Years 76 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS

15 Robert P. Harrison, Registrar

JAN 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 19 24

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1919, to January 11, 1924, that I last saw h im alive on January 11, 1924, and that death occurred, on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Mona, M. D.

1-12-24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JAN 15 1924

20 UNDERTAKER: Commissioner Health.

ADDRESS

Spec.—1-10-21 M&T 1500 Blks.

D 82747

HEALTH DEPARTMENT—CITY OF BALTIMORE

1625 82747

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

2-FULL NAME Baby Shores

(a) RESIDENCE No. 25 W Culey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				10 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Shores

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital

Filed JAN 15 1924, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Jan 12, 1924, that I last saw him alive on Jan 12, 1924 and that death occurred, on the date stated above, at 2:00 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis. Congenital

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E E Duncan M. D.

1/12, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 15 1924

20 UNDERTAKER Commissioner Health,

ADDRESS

Pur. Wm. K. WOOBALL

JAN 15 1924

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82748

CERTIFICATE OF DEATH.

90 D 82748

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Park ave Hamilton Boulevard St., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Georges

(a) RESIDENCE NO. 105 Park Ave Hamilton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Jacob M. Georges

6 DATE OF BIRTH (month, day, and year) Nov 6th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ? Dilfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Fred Dickert

(Address) 105 Park ave Hamilton

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1924

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to Jany 14, 1924.

that I last saw her alive on Jany 13, 1924

and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Green, M. D.

1/15. 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jany 17th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 Hanover St

JAN 15 1924

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82749

74-001

74 D 82749

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 S. Charles ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Knapp Sr.

(a) RESIDENCE NO. 1827 S. Charles ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evaline C. Knapp

6 DATE OF BIRTH (month, day, and year) Sept. 27. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. 086

(b) General nature of industry, business, or establishment in which employed (or employer) N.E. Stamping Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jno. Knapp

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mont Snow

13 BIRTHPLACE OF MOTHER (city or town) Mont Snow (State or country)

14 Informant Mrs. Earnest Griffiths (Address) 1521 S. Charles St.

15 JAN 15 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 14, 1924, that I last saw h alive on Jan 10, 1924, and that death occurred, on the date stated above, at 12-30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) A. L. L. Campbell M. D.

Jan 16, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Jan 16 1924

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1122 Light St

[Burial Permit Clerk.]

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information of interest should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82750

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 S. Carey ST.: 18 WARD)

2-FULL NAME Mary L. Cruddan

(a) RESIDENCE. No. 15 S. Carey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Cruddan

6 DATE OF BIRTH (month, day, and year) July 19-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Cruddan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cork Ireland

12 MAIDEN NAME OF MOTHER Mary J. McBan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mary Allen
(Address) 15 S. Carey St

15 Filed JAN 15 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—13—1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 13, 1924, that I last saw h[illegible] alive on Jan 13, 1924, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis, Chronic Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Diagnosis

(Signed) T. Wells Hemmings M. D.

1/15, 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1/16th 1924
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun Hollins st

JAN 15 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82751

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82751

CERTIFICATE OF DEATH.

175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2526 Calvert St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norris W Brown

(a) RESIDENCE NO. 2526 Calvert St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1 1909

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
14	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John W Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John W Brown

(Address)

15 Filed: Jan 15 1924, 19

Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924 to Jan 15, 1924

that I last saw h[illegible] alive on Jan 15, 1924

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Hemorrhage

Duration

CONTRIBUTORY (Secondary) Arteriosclerosis (Chronic) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — (over)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Richardson M. D.

Jan 15, 1924 (Address) 1132 N. Gay St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 17 1924

20 UNDERTAKER: CHENOWETH & SON — ADDRESS: 3617 CHESTNUT AVE.

JAN 15 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Physician does'nt know,
But thinks it was due to something
that he had eaten.

Cor.—1-12-23—M&T—100 Blks.

D 82752

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D 82752

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Castle & Fayette ST., 6 WARD)

2-FULL NAME Abraham Lahn

(a) RESIDENCE NO 2232 E. Fairment Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Lahn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Maurice Lahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Stella --------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rebecca Lahn
(Address) 2232 E. Fairment Ave

15 Filed JAN 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilitation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Powers M. D.
(Given)

Jan 15/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	1/16 192 4
20 UNDERTAKER Falk Bros 1434	ADDRESS E Balto

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—150) Blu.

32753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3108 Fairfield St., 25 WARD)

2-FULL NAME Alexander Green

(a) RESIDENCE NO. 3108 Fairfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Katie Green

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	— —	— —	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

12 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Katie Green

(Address) 3108 Fairfield

15 JAN 16 1924 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-14 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov-7, 1923 to Jan-14, 1924

that I last saw him alive on Jan 14, 1924

and that death occurred, on the date stated above, at 1:10 P. M.

The CAUSE OF DEATH was as follows:

Valvular lesion of the heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Coleman M. D.

, 19 (Address) 2039 McCulloh.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn Cem	1/16 1924
20 UNDERTAKER	ADDRESS
James H. Skinner	1625 E. Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—4000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82754

CERTIFICATE OF DEATH.

100-001

D 82754

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Patterson

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1847

7-AGE. 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country), Unknown

14- (Informant) Municipal Hospital Records

(Address)

JAN 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 5 19 24, to January 12 19 24, that I last saw h. in alive on January 12 19 24, and that death occurred, on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Dunca, M. D

1-14-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel	Jan 16 1924
20-UNDERTAKER, Wm R A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82755

12 D 82755

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Cove Ave ST., 18 WARD)

2-FULL NAME Louisa Knott

(a) RESIDENCE NO. 221 Cove Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E Knott

6 DATE OF BIRTH (month, day, and year) March 16 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Chollett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant L E Knott

(Address) 221 Cove Ave.

15 JAN 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Jan 14, 1924, that I last saw h alive on Jan 14, 1924, and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Obstruction Jaundice

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Jake Stones

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? J Harwood

(Signed) , M. D.

Jan 16 1924 (Address) 731 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jones sta. Round Bay Md	Jan 17 1924

20 UNDERTAKER J. B. Thomas' Son

ADDRESS 108 W. Mount St

13, W. & A. R.R. Electric Line

Spec—12-23-21—E.B.R.S.—400 Eks.

D 82756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82756

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 837 S. Paca St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Henry Bennett Jr.....

(a) Residence No. 837 S. Paca St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 14, 1924

7-AGE.	If LESS than 1 day.
....yrs. ....mos. 1 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER, Wm. H. Bennett

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ethel May Smith

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore
(State or Country), Maryland

14-
(Informant)..... Wm. H. Bennett
(Address)..... 837 S. Paca Street.

15-
JAN 16 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 14 1924 to Jan 15 1924 that I last saw him alive on Jan 15 1924 and that death occurred, on the date stated above, at 8.55 A.M.

The CAUSE OF DEATH* was as follows:

Nasal Hemorrhage

(Duration)..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration)..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) H. Hammerbacher, M. D.

1 15 1924 (Address) 835 Light St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cem	Jan 16 1924 BH
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82757

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 82757

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N. Peale ST., 4 WARD)

2-FULL NAME Helena Liberto

(a) RESIDENCE NO. 318 N Peale st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. 15 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Singer

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 1. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Angelo Liberto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Mary Ciccone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Angelo Liberto

(Address) 318 N. Peale st

JAN 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15-1924

17 I HEREBY CERTIFY, That I attended deceased from 1-15-, 1924, to 1-15-, 1924, that I last saw h[illegible] alive on 1-15-, 1924, and that death occurred, on the date stated above, at 5-30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia.

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Edmund [illegible], M. D.

1-16, 1924 (Address) 1504 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 16 1924

20 UNDERTAKER [illegible] ADDRESS 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82758

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1705 Presbury ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Green

(a) RESIDENCE. No. 1705 Presbury ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: P. Green.

6 DATE OF BIRTH (month, day, and year): April 4 / 1852

7 AGE: Years 71 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bald. County.

PARENTS

10 NAME OF FATHER: Charles Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt. County

12 MAIDEN NAME OF MOTHER: M. DeCosey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt. County.

14 Informant: Mrs Hannie Cassell.

(Address) 1705 Presbury. st.

JAN 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Jan 14th 1924

that I last saw h alive on Jan 14th, 1924.

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cancerchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Constipation Cause

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. H. Zuellenbach. M. D.

Jan 14. 1924 (Address) 2215 N. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery.

DATE OF BURIAL: Jan 16 1924

20 UNDERTAKER: Geo. J. Ruth.

ADDRESS: 1735 Hayford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82759

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 E. Preston ST., 8th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson Taylor

(a) RESIDENCE NO. 1734 E. Preston ST., 8th WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Taylor

6 DATE OF BIRTH (month, day, and year) July 12, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Oil

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Nelson Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Webber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ethel Taylor

(Address) 1734 Preston

15 JAN 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 14, 1924

that I last saw him alive on Jan 13, 1924

and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Story, M. D.

1/15 1924 (Address) 647 Winchester

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian	Jan 17 1924
20 UNDERTAKER Herbert Parker	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82760 (Demoss)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. + 65-00 D 82760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Demoss

(a) RESIDENCE NO. Jerome Md (1 St.,) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. (in Jerome 6 months) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or estsblishment in which employed (or employer) Clerk. Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER David Demoss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Hollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records

(Address)

15 Filed JAN 16 1924 19 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14/24. 19

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18-23, 19.... to 1/14/24, 19....

that I last saw him alive on 1/14/24, 19....

and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted ? If not at place of death? ? Removal of Bladder

Did an operation precede death? Yes Date of 12/3/23.

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path.

(Signed) K. W. Galley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 17 19 24

20 UNDERTAKER E. A. Windsfeld — ADDRESS 501 E 24 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 82761

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2707 Presbury St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lena Bety

(a) Residence No. 2707 Presbury St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced of HUSBAND of (or) WIFE of Wm. Bety

6-DATE OF BIRTH (month, day and year) July 3, 1870

7-AGE. 53 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER. John Schwartz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14-(Informant) Catherine Bety

(Address) 2707 Presbury St

15-

JAN 16 1924

ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923 to Jan 14, 1924

that I last saw h. alive on Jan 15, 1924

and that death occurred, on the date stated above, at 2:20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

This.

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Emile A Klauber M. D

1/16, 1924 (Address) 212 9 Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cem	Jan 17, 1924
20-UNDERTAKER. H. Sander Sons	ADDRESS 1710 Pleasant

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82762

CERTIFICATE OF DEATH.

44 D 82762

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 702 N. Gilmor St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Absalom Knox

(a) Residence No. 702 N. Gilmor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma Mann Knox

6-DATE OF BIRTH (month, day and year) Jan 24th, 1873

7-AGE. 50 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Central M. E. Ch. South

018

9-BIRTHPLACE (city or town) (State or Country): Courtland Miss.

PARENTS.

10-NAME OF FATHER: John L. Knox

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee

12-MAIDEN NAME OF MOTHER: Sophronia Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Mississippi

14-(Informant): Rev John Knox

(Address): 702 N. Gilmor St

JAN 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 15th, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 2 19 23 to Jan 15 19 24

that I last saw him alive on Jan. 14 19 24

and that death occurred, on the date stated above, at 5-20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Oct. 11-1923

Was there an autopsy? No

What test confirmed diagnosis? Path. Lab.

(Signed) Homer C. Todd M. D.

1/15 1924 (Address) 735 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge Cemetery	Jan 17th, 19 24
20-UNDERTAKER, Bertram Cole	ADDRESS 1723 N. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82763

CERTIFICATE OF DEATH.

1923 D 82763

1-PLACE OF DEATH Colonial Hospital

Registered No. C.....

City of BALTIMORE: (No..... St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene H. Webb

(Residence in Baltimore: No. 1506 Linden Ave. St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. April (Month) 23 (Day) 1910 (Year)

7-AGE. 13 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Clay W. Va.

PARENTS.

10-NAME OF FATHER, Wade H. Webb

11-BIRTHPLACE OF FATHER, (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER, Anna King

13-BIRTHPLACE OF MOTHER, (State or Country), W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wade H. Webb

(Address) 1506 Linden Ave.

15- C. HAMILTON JAMES, ROBERT N. DENNIS, COMMISSIONERS OF HEALTH.

JAN 16 1924 Burial Permit Granted. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 12 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun-shot in Head

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Accidental (Fell on his rifle)

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. J. Hennessy M. D. (Coroner.)

Jan. 15 1924 (Address) 2807 Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, January 16 1924

20-UNDERTAKER, Harry Hilbitzke ADDRESS 5-31 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82764 ✓ 24 101-001 D 82764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1470 Reynolds St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Mazur

(a) Residence No. 1470 Reynolds St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of ~~XXXXXX~~ Wladyslawa. Mazur

6-DATE OF BIRTH (month, day and year) June 10 1879

7-AGE.	If LESS than 1 day,
44 yrs. 7 mos. 5 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Steveodore 074

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS:

10-NAME OF FATHER. Anthony. Mazur.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Frances. Kempinski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Mrs. Wladyslawa. Mazur

(Address) 1470 Reynolds Street

15-

JAN 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 31 1923 to Jan 15 1924

that I last saw h~~im~~ alive on Jan 14 1924

And that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos J Stevens M. D

6—15—1924 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Jan 18 1924

20-UNDERTAKER.	ADDRESS
John M Weber	1803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Hks.

D 82765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

74 D 82765

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Battery Ave St. 74 WARD)

2-FULL NAME Ann. Sorensen

(a) RESIDENCE. No. 1512 Battery Ave St.: WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced (or) WIFE of: Niles Sorensen

6 DATE OF BIRTH (month, day, and year): Feb 8. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St Thomas West Indias.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Indias.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Annie Kjeldsen (Address) 1512 Battery Ave

15 Filed JAN 16 1924 19 Burial Permit Clerk. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924, to Jan 15, 1924 that I last saw h.. alive on Jan 15, 1924 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) S. H. Streett, M. D.

1/18 1924 (Address) 445 E Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	1/18 1924
20 UNDERTAKER	ADDRESS
J. F. McCully	130 E. Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82766

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 aliceanna ST., 2 WARD)

2-FULL NAME Katharine King.

(a) RESIDENCE No. 1921 aliceanna ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Wm King.

6 DATE OF BIRTH (month, day, and year) Jan. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) German Poland.

PARENTS

10 NAME OF FATHER John Jandzinska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Dont Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Cecelia Kimmelman

(Address) 1921 Aliceanna St

15 JAN 16 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Jan 14, 1924,

that I last saw h[er] alive on Jan 14th, 1924,

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis, 6 hours

Diffuse Nephritis, Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Asthma & Heart failure

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jos. A. Rutkowski, M. D.

1/16, 1924 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Jan 17 1924

20 UNDERTAKER Lilly-Zeiler ADDRESS 1033 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

CERTIFICATE OF DEATH.

D 82767

D 82767

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dorsey

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1863

7-AGE: 60 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14- (Informant) Municipal Hospital Records

(Address)

15- JAN 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 12, 1924.

17- I HEREBY CERTIFY, That I attended deceased from November 19 19 23 to January 12 19 24, that I last saw him alive on January 11 19 24, and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clark G. Heuer M. D

1-14-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: S HOPKINS HOSPITAL | DATE OF BURIAL, 19....

20-UNDERTAKER, Commissioner Health, per Wm. R. Woodall | ADDRESS JAN 16 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

18.

body at city morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82768

101-001

D 82768

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 Sarah ann St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Legonz

(Residence in Baltimore: No. 806 Sarah ann st St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Don't Know

6-DATE OF BIRTH: ..... Don't Know ..... 1..... (Month) (Day) (Year)

7-AGE: 45 about yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 40
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Don't Know

PARENTS.

10-NAME OF FATHER: (")

11-BIRTHPLACE OF FATHER, (State or Country): (")

12-MAIDEN NAME OF MOTHER: (")

13-BIRTHPLACE OF MOTHER, (State or Country): (")

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Sons

(Address):

15- Filed JAN 16 1924 HUBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan ..... 16 ..... 192 4 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held on.....(Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia History & Work
Lobar Pneumonia

.....(Duration) .....yrs. .....mos. 4 .....ds.

CONTRIBUTORY (Secondary) Don't Know

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) H. A. Comegys M. D. (Coroner.)

1 16 1924 (Address) 1017 Eastern Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL DATE OF BURIAL, ... 19..

20-UNDERTAKER, Commissioner Health. ADDRESS JAN 16 1924

Par. Wm. E. WOODALL

N. B.—Every item of information should be carefully supplied. A state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

WHITE PAPER. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82769

REGISTERED NO. 1001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 824 N Payson ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Unger

(a) RESIDENCE. No. 824 N Payson St. WARD. 16

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank B Unger

6 DATE OF BIRTH (month, day, and year) Sept 18 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant 803 Unger

(Address) 824 N Payson

15 [illegible]

JAN 16 1924 HUBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-9-24, 19..., to 1-14-, 1924, that I last saw her alive on 1-14-, 1924, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Boyd McCleery, M. D.

1/14 1924 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/17/24

20 UNDERTAKER Finley Sutton & Smith

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Boulevard

D 82770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82770

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Allen Ave. ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Coburn Moore

(a) RESIDENCE No. 2702 Allen Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joanna Elizabeth

6 DATE OF BIRTH (month, day, and year) Sept 8 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	71			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Boilermaker
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs Ida Emerson
(Address) 2702 Allen Ave

15 Filed 192
Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonar disease
X Mark

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Sam H Morrison (Coroner), M. D.

1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs., ...mos., ...ds. In the State.....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan. 17 1924
20 UNDERTAKER	ADDRESS
Wm Cook Sons & Stanton	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Blks.

Dr Olson
Potomac

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82771

CERTIFICATE OF DEATH.

129

D 82771
Fairmount

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 2218 Eager Place St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Claudice

(a) Residence No. 2218 Eager Place St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

No. 8

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Geo J Claudice Sr

6-DATE OF BIRTH (month, day and year): unknown

7-AGE. About 66 yrs. ..... mos. ..... dls.
If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of Industry, business, or establishment in which employed (or employer): 137
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS:
10-NAME OF FATHER: Rann Claudice
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-Informant: Jas B. Claudice
Address: 2218 Eager Place

15-Filed Jan 16 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1923 to Jan 15 1924
that I last saw h. alive on Jan 15 1924
and that death occurred, on the date stated above, at 1P m.
The CAUSE OF DEATH* was as follows:

Myocardial - Insufficiency
(Duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(Duration) ..... yrs. 6 mos. ..... ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) John B Olson M. D
Jan 15 1924 (Address) 35 N Potomac St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Fairmount
DATE OF BURIAL: 1/17 1924

20-UNDERTAKER: Wm Cook
ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 82772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82772

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 76 WARD)

2-FULL NAME Harry Samuels

(a) RESIDENCE No. 630 S. 14th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? X yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 40

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER Morgan Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales.

12 MAIDEN NAME OF MOTHER Ann — ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales.

14 Informant Municipal Hospital Records. (Address)

15 Filed JAN 16 1924, 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1924

17

I HEREBY CERTIFY, That I attended deceased from January 10, 1924 to January 13, 1924, that I last saw him alive on January 13, 1924, and that death occurred, on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Uremia + Bronchopneumonia (duration) yrs. mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude A. Ireland, M. D.

(Address) Municipal Hospital. 1-14-1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL Jan. 17 1924

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82773

CERTIFICATE OF DEATH.

100-09 D 82773

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 Light St., 23 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris-May C. Burchett

(a) Residence No. 1510 Light St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 15 1922

7-AGE.	If LESS than 1 day.
2 yrs. 1 mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Major C Burchett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wilkes Co N.C.

12-MAIDEN NAME OF MOTHER, Anna G. Houchins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

11- (Informant) Major C Burchett

(Address) 1510 Light St

15- Robert P. Harrison, Registrar.

JAN 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924 to Jan 15, 1924

that I last saw he alive on Jan 14, 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute Coronae Thrombosis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert Bruce M. D.

19 (Address) 1 W Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	Jan 17, 1924
20-UNDERTAKER. John F. Denny	ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: Your CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 ✓ D 82774

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 731 Euclid Ave (St.) Roland Park (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Davis

(a) RESIDENCE No. 731 Euclid Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M Davis

6 DATE OF BIRTH (month, day, and year) Aug 27 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Clerical 009

(b) General nature of industry, business, or establishment in which employed (or employer)..... Insurance

(c) Name of employer Griffith Insurance Co

9 BIRTHPLACE (city or town) (State or country) Hamilton Va

PARENTS

10 NAME OF FATHER Francis Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Maria E Krut

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Ida M Davis

(Address) 731 Euclid Ave Balto

15 Filed JAN 6 1924, 19.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1924, to Jan. 14, 1924.

That I last saw him alive on Jan. 14, 1924,

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis. High blood pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? To my knowledge / —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Dustin F. Robinson, M. D.

11-16 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druids Cemetery	Jany 17 1924
20 UNDERTAKER W J Fickenscher	ADDRESS Northam

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82775

CERTIFICATE OF DEATH.

49 D 82775

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 817 Arlington ave ST., 16 WARD)

2-FULL NAME Ursula Xavier Abendschoen

(a) RESIDENCE NO. 817 N. Arlington Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ursula Abendschoen

6 DATE OF BIRTH (month, day, and year) Aug 20 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	68	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor 680
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gregory Abendschoen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Goder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ursula Abendschoen
(Address) 817 Arlington

15 Filed JAN 16 1924, 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923 to Jan 14 1924.
That I last saw h.. alive on Jan 14 1924,
and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lungs.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

What was there an autopsy? no.

What test confirmed diagnosis? X-ray

(Signed) W. J. Hamm M. D.

(Address) 18 W Mt Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Jan 17
UNDERTAKER Hart & Tuckerson Sons	ADDRESS Norther

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82776

CERTIFICATE OF DEATH.

31 D 82776

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Piedmont Rd (St.) 27 (Ward)

2-FULL NAME William Wessel

(a) RESIDENCE. No. 1 Piedmont Rd St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Wessel

6 DATE OF BIRTH (month, day, and year): Aug 9, 1878

7 AGE: Years 45 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: H. Wessel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: M. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Margaret Wessel

(Address) 1 Piedmont Ave

15 Filed JAN 1 6 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Jan 15, 1924

that I last saw him alive on Jan 15, 1924

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Gemma Cox M. D.

1/16 1924 Address 2717 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 1/17 1924

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful that it may be properly classified. Exact statement of OCCUPATION of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1921 M&T 1500 Blks.

(Schoon)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82777

CERTIFICATE OF DEATH.

X 100 D 82777

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos O. Scoon (Schoon)

(a) RESIDENCE (Usual place of abode) No. ST., WARD Rock Hall Md.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fish & Oysters

(b) General nature of industry, business, or establishment in which employed (or employer): 045 Jr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rock Hall Maryland

PARENTS

10 NAME OF FATHER Geo. W. Schoon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rock Hall Do not know Md

12 MAIDEN NAME OF MOTHER Martha J. Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Md

14 Informant: Alfred Scoon

(Address) Rock Hall Md

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

JAN 16 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 1924, to June. 16 1924, that I last saw him alive on June. 16 1924, and that death occurred, on the date stated above, at 6 35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - terminal
Pulmonary oedema -
Pneumonia followed operation
for perineal fistula (duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Y Date of 10-15-23 1-4-24

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) W. Alexander Mowey M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Md	Jan 17 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

D 82778 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 D 82778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 921 Vincent St. St., 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Thomas Jones

(Residence in Baltimore: No. 921 Vincent St. St., 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): widower

6-DATE OF BIRTH: about ..... (Month) ..... (Day) 1861 (Year)

7-AGE: 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer odd
(b) General nature of industry, business, or establishment in which employed (or employer): (general)

9-BIRTHPLACE, (State or Country): Calvert Co. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kellum

(Address) 921 N. Vincent St.

15- JAN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 14, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 1 yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy M. D. (Coroner.)

Jan. 15 1924 (Address) 2807 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, 1-17-, 1924

20-UNDERTAKER, Samuel Easton — ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82779

CERTIFICATE OF DEATH.

38 D 82779

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1128 Laurens St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Wade

(a) Residence No. 1128 Laurens St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Deceased~~

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer). Private

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER George Ball

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Washington D.C.

12-MAIDEN NAME OF MOTHER. Etta Ball

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Washington D.C.

14-

(Informant). Robert Hardy

(Address) 1128 Laurens St

15 JAN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 15/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1923 to Jan 15 1924

that I last saw her alive on Jan 15 1924

and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Acute Valvular Heart Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey M. D

1/16, 1924 (Address) 1928 Pa Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Washington D.C. DATE OF BURIAL. 1-17-1924

20-UNDERTAKER. Daniel Easton ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably Lueti
Alcoholism

Spec—12-23-21—E.B.R.S—400 Blks.

D 82780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32780

CERTIFICATE OF DEATH.

89

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3825 Parkheightstand St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louis Kaufman

(a) Residence No. 3825 Parkheightstand St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 25 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rhumine Kaufman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 77 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- JAN 17 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 16 24

17- I HEREBY CERTIFY, That I attended deceased from June 16 1924 to June 16 1924 that I last saw h. alive on June 17 1924 and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Congestive Pneumonia.

10 days

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

5 years

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Albert H. Levy M. D.

1/16/24 (Address) 1235 E. Lombard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Hebron Memory Park — DATE OF BURIAL. Jan 17 1924

20-UNDERTAKER. Jack Lewis — ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Charles s 31 st St ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Tossey Keller

(a) RESIDENCE NO. Homewood Apt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	5	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Detroit
(State or country) Mich

PARENTS

10 NAME OF FATHER A. Torrey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mass

12 MAIDEN NAME OF MOTHER Kate Foote

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mich

14 Informant Mrs Keller
(Address) 31st & Charles St Ave

Filed JAN 17 1924
ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1924

17 I HEREBY CERTIFY, That I attended deceased from August, 1923, to January, 1924, that I last saw her alive on January, 1924, and that death occurred, on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 20 yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? In Detroit at age of 16

Did an operation precede death? O Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Sydney R Keller, M. D.

, 19 (Address) 700 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Detroit Mich	Jan 16 1924
20 UNDERTAKER	ADDRESS
Henry Jenkins & Son Co	Orchard & Mt Hollyk

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82782

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 82782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH.

City of BALTIMORE: (No. 1013 Madison Ave. St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Francis Peerce

(a) Residence No. 1013 Madison Ave. St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 if yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rose A. Peerce

6-DATE OF BIRTH (month, day and year) July 26, 1844

7-AGE. 79 yrs. 5 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Night Manager 86

(b) General nature of Industry, business, or establishment in which employed (or employer)..... The Rochambeau

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Peerce

11-BIRTHPLACE OF FATHER (city or town). Unknown
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Ann Fitzsimmons

13-BIRTHPLACE OF MOTHER (city or town). Unknown
(State or Country),

14- (Informant) Rose A. Peerce

(Address) 1013 Madison Ave.

15 JAN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 15th 1924 to January 16th 1924

that I last saw h[illegible] alive on January 15th 1924

and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar S. Perkins M. D.

1-16-, 24 (Address) The Rochambeau Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	1/19/24 19....
20-UNDERTAKER.	ADDRESS
Joseph B Cook & Son	W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 11 7 0 82783

82783

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Hanover St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Kraft

(a) RESIDENCE No. Hamilton P.O. Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter A. Kraft

6 DATE OF BIRTH (month, day, and year) March 18, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER David W Bailey

11 BIRTHPLACE OF FATHER (city or town) Port Deposit (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie M. Black

13 BIRTHPLACE OF MOTHER (city or town) Oxford (State or country) Pa

14 Informant Walter A. Kraft (Address) Haleth P.O. Maryland

15 JAN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-14-24 to 1-16-24, that I last saw h[illegible] alive on 1/16/24 and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows: Acute appendicitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis of mesentery

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1/15/24

Was there an autopsy? No Appendectomy

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1-16 24 (Address) Mt Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Jan 19 1924

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82784

CERTIFICATE OF DEATH.

74 001

D 82784

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2818 E. Baltimore ST., 6 WARD)

2-FULL NAME Anna J. Johnson

(a) RESIDENCE NO. 2818 E. Baltimore ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ John F. Johnson

6 DATE OF BIRTH (month, day, and year) Jan 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	67	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 000

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Billyacho

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Briggler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. M. Crawford. (Address) 2818 E. Balto St.

15 Filed JAN 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1924, to Jan 14, 1924,

that I last saw her alive on Jan 14 1924

and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. N. Meyer D, M. D.

1/16, 1924 (Address) 2138 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 1/17 1924

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto.

Cor.—1-12-23—M&T—100 Bks.

D 82785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82785

CERTIFICATE OF DEATH.

5 5

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1419 E. Monument ST., 5 WARD)

2-FULL NAME Louise Schaefer

(a) RESIDENCE No. 343 Forrest ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Schaefer

6 DATE OF BIRTH (month, day, and year): Dec. 15/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66		30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER — Hilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Chas. A.J.Schaefer
(Address): 2113 Sinclair Lane

15 JAN 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Jan 14/24 (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion-probably due to gastric or pancreatic lesion

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) History of Diabetes Mellitis (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mc Coll, M. D.
(Coroner.)

Jan 16/24 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery Druid Hill Park	Jany 17 1924
20 UNDERTAKER	ADDRESS
Harry A Amacost	4204 Ridgewood Ave

MATTERS REQUIRED BY LAW TO BE REPORTED ON THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82786

CERTIFICATE OF DEATH.

D 82786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington Vol. Hospital; 18 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mollie Stein

(a) RESIDENCE. No. 906 W Franklin ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 10 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Dutch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bertha M Kohler
(Address) 906 W Franklin St.

15 Filed JAN 7 1924 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1923, to Jan 16, 1924, that I last saw her alive on Jan 15, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Fracture of neck of rt. femur

(duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sign in chest.

(Signed) Dr. E. S. Johnson, M. D.

19 (Address) 1212 St Paul.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery	Jany 18 1924

20 UNDERTAKER Harry R Arnold ADDRESS 4204 Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

82787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 82787

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 822 S. East ave. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James D. Metzdorf

(a) Residence No. 822 S. East ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6-DATE OF BIRTH (month, day and year) Feb 15 1922

7-AGE. 1 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, James F. Metzdorf

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Queenstown, Md

12-MAIDEN NAME OF MOTHER Anna V. Dexter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md

14-(Informant) Anna V. Metzdorf

(Address) 822 S. East Ave

15-JAN 7 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan-16-1924

17- I HEREBY CERTIFY, That I attended deceased from 15 Jan 1924 to Jan 16 1924 that I last saw h— alive on 16 Jan 1924 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Mixture. Neutral Wright

(Signed) [illegible], M. D.

19 (Address) 2015 Ellwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Carmel Cem	Jan. 17, 1924
20-UNDERTAKER.	**ADDRESS**
Zirkler & Zirkler	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

82788

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ D 82788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 White St. ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Massal

(a) RESIDENCE NO. 1800 White St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel L. Wormley Massal

6 DATE OF BIRTH (month, day, and year) Oct. 18. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42.	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 043

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Massal.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Hannah Dunn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Isabel L. Massal.
(Address) 1800 White St.

15 JAN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1923, to Jan. 15th, 1924, that I last saw him alive on Jan. 15th, 1924, and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) J. Dawson Sueder M. D.

19 (Address) 30 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 19 24
20 UNDERTAKER John F. Howard & Son	ADDRESS
Chas F. Howard	901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82789

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Hanover. ST., 22 WARD)

2-FULL NAME John H Berger.

(a) RESIDENCE No. 823 Hanover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stella Berger.

6 DATE OF BIRTH (month, day, and year): Nov 21st 1869

7 AGE: Years: 54 | Months: | Days: | If LESS than 1 day, ... hrs. or ... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 034

(b) General nature of industry, business, or establishment in which employed (or employer): Night Watchman

(c) Name of employer: City

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Morris Berger.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Stella Berger.

(Address) 823 Hanover St

15 JUN 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Jan 15, 1924,

that I last saw h[illegible] alive on Jan 14, 1924,

and that death occurred, on the date stated above, at 2 40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 5 ... ds.

CONTRIBUTORY (Secondary): Chronic Bright's Disease

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mitchell M. D.

1/15, 1924 (Address) 1179 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: 1-18th 1924

20 UNDERTAKER: Ellis Haler

ADDRESS: 115 E North St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 82790

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Eber Jr.

(a) RESIDENCE NO. 2559 W. Fairmount Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept 18 1923

7 AGE: Years / Months 3 / Days 29 / If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frederick Eber.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt.

12 MAIDEN NAME OF MOTHER: Lillian Hohman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Record Examined By

15 JAN 17 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/16 1924

17

I HEREBY CERTIFY, That I attended deceased from 1/14/24, 19.., to 1/16, 19 24

that I last saw him alive on 1/16/24, 19.....,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

Generalized miliary T.B.

Amend

Uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Inspection

(Signed) R. D. Pfeiffer, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: 1-17 1924

UNDERTAKER: E & B Hardt 112

ADDRESS: Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D 82791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82791

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 E Eager ST., 10 WARD)

2-FULL NAME Mary T. Sayles

(a) RESIDENCE NO. 1008 E Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James. H. Sayles

6 DATE OF BIRTH (month, day, and year) Jan. 22 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	33	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Patrick J Hepburn

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Coltart

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mr. James H. Sayles
(Address) 1008 E Eager St

15 JAN 17 1924 HENRY R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to Jan 15 1924, that I last saw h[illegible] alive on Jan 15 1924, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
Metastasis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 23

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Forrest F Kellogg M. D.

19 (Address) 458 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 18 1924
20 UNDERTAKER Henry Hoen & Son	ADDRESS 1401 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 82792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 82792

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 McHenry ST.: 19 WARD)

2-FULL NAME Victoria A. Godfrey

(a) RESIDENCE. No. 1602 McHenry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexandria M. Godfrey

6 DATE OF BIRTH (month, day, and year): Apr. 27 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62.	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Greensboro N. C.

PARENTS

10 NAME OF FATHER: Wm Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Elizabeth Gales

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Alexandria M. Godfrey

(Address): 1602 McHenry St.

15 Filed JAN 7 1924, 19.. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 15th 1924

17

I HEREBY CERTIFY, That I attended deceased from January 10th, 1924, to January 15th, 1924, that I last saw her alive on January 15th, 1924, and that death occurred, on the date stated above, at 11.40 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Exposure & Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal observation.

(Signed) Wm Conrad Boke, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greensboro. N. C.	Jan. 17 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Fredk. Ave.

Spec.—1-10-21—M&T—1500 Blks.

D 82793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 82793

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3314 Carlisle Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felicita Cestero de Jimenez

(a) RESIDENCE NO. 3314 Carlisle Av ST., 15 WARD Resident

(Usual place of abode) (If non-resident give city or town and state)

Length of residence in city or town where death occurred 22 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 22 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lino J. Jimenez

6 DATE OF BIRTH (month, day, and year) August-25-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	57	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Santo Domingo

(State or country) Santo Domingo West Indies

PARENTS

10 NAME OF FATHER Venceslao Cestero

11 BIRTHPLACE OF FATHER (city or town) Santo Domingo

(State or country) West Indies.

12 MAIDEN NAME OF MOTHER Faleuita Martinez

13 BIRTHPLACE OF MOTHER (city or town) Santo Domingo

(State or country) West Indies

14 Informant Mr. Lino J. Jimenez (Husband)

(Address) 3314 Carlisle Av. City

15 Filed JAN 17 1924 ROBERT R. KNABE, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13 1924

17

I HEREBY CERTIFY, That I attended deceased from January 13, 1924, to January 13, 1924.

that I last saw h er alive on January 13, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio. sclerosis Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Samuel Wolmer, M. D.

, 19 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Jan 17 1924

20 UNDERTAKER STEWART & MOWEN COMPANY, WILLIAM P. MOWEN, Successor — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. INSTRUCTION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 82794

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 82794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 607 Brook Ave. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie E. Sharer

(a) Residence No. 607 Brook Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Sharer

6-DATE OF BIRTH (month, day and year) Aug 9 1886

7-AGE.	If LESS than 1 day,
37 yrs. 5 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) housewife 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frederick C. Emrich

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Meta Levyjisky

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Charles E. Sharer

(Address) 607 Brook Ave.

15-

JAN 17 1924 [illegible] Registrar

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 15 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 14 1923 to Jan 15 1924

that I last saw her alive on Jan 15 1924

and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N G Davis M. D.

1/16, 1924 (Address) 720 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn	Jan 18, 1924
20-UNDERTAKER.	ADDRESS
Joseph Dyer	1600 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82795

91-002 D 82795

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6217 Bolton ST.; 11 WARD)

2-FULL NAME Laurence Streett

(a) RESIDENCE. NO 1217 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ May V. Streett

6 DATE OF BIRTH (month, day, and year) aug 26 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Coach painter

(c) Name of employer My employed.

9 BIRTHPLACE (city or town) Rock Hall
(State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER Erskin G. Streett

11 BIRTHPLACE OF FATHER (city or town) Harford
(State or country) County. Md.

12 MAIDEN NAME OF MOTHER Ann Streett

13 BIRTHPLACE OF MOTHER (city or town) Harford
(State or country) Co. Maryland.

14 Informant Mrs May Streett
(Address) 1217 Bolton St

JAN 17 1924 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924 to Jan 16, 1924.

that I last saw h.m alive on Jan 14, 1924

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Arteo Sclerosis with
Hy pertension,

(duration) 8 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Cart Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E B Freeman, M. D.

, 19 (Address) 412 Cathedral St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem	Jan 17 1924
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32796

CERTIFICATE OF DEATH.

45

D 32796

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Maryland Av ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Waters Ridgely

(a) RESIDENCE. NO. 2116 Maryland ST. Av WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 7, 1849

7 AGE — Years: 74 Months: 8 Days: 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Station master

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R. 73

(c) Name of employer: Prince George Co Md.

9 BIRTHPLACE (city or town) (State or country): Prince George Co Md.

PARENTS

10 NAME OF FATHER: Arthur P. Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Md

12 MAIDEN NAME OF MOTHER: Selah Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Montgomery Co. Md

14 Informant: Clara D Ridgely

(Address): 933 W Franklin St

15 JAN 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1923, to Jan 14, 1924, that I last saw h~~e~~ alive on Jan 14, 1924, and that death occurred, on the date stated above, at 9 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

Carcinoma Colon

primary. lesion (duration) One yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? ~~Microscopic~~ Autopsy findings Clinical Symptoms Autopsy

(Signed) J Lynn Chaney, M. D.

, 19 (Address) 25 E Lan Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan 17, 1924

20 UNDERTAKER: A. S. Marshall

ADDRESS: 3537 Falls Road Baltimore, Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82797

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital Registered No. 159

City of BALTIMORE: (No. ..... St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph George (Colored) Roland Park

(a) Residence No. 190 Cedar Ave., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6-DATE OF BIRTH (month, day and year) Jan 7, 1924

7-AGE. ..... yrs. ..... mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore

(State or Country), Md

PARENTS.

10-NAME OF FATHER, Frederick George

11-BIRTHPLACE OF FATHER (city or town) Balto

(State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Berry

13-BIRTHPLACE OF MOTHER (city or town) Balto

(State or Country), Md

14-

(Informant) Frederick George

(Address) 190 Cedar Ave

15. JAN 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 16/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 16, 1924, that I last saw him alive on Jan 15, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) premature

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo N Zurler, M. D

, 19 (Address) 1173 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross, Hanford Rd — DATE OF BURIAL. Jan 17, 1924

20-UNDERTAKER. Wm. Leo Koch Sons — ADDRESS E Monument Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82798

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 82798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd and Calvert ST. (or WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Bartholomee

(a) RESIDENCE NO. 16 E. White ST. Ave, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year) Jan 1- 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	~~1~~ 1	~~1~~ 0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Theodore M. Bartholomee

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gladys Coleman

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Theodore M Bartholomee (Address) 16 E White, Hamilton Rd

15 JAN 17 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from January 15 1924 to January 16, 1924, that I last saw him alive on January 10, 1924, and that death occurred, on the date stated above, at 8 03 P m.

The CAUSE OF DEATH* was as follows:

1. Bone resolved pneumonia
2. Empyema

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 16, 1924.

Was there an autopsy? Yes

What test confirmed diagnosis? Staphylococcus

(Signed) Carl Rothfuss, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Jan 19 1924

20 UNDERTAKER: Wm. Cook Sons & Thomas — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82799

CERTIFICATE OF DEATH.

99-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gershun Lasdin

(a) Residence No. 115 Aisquith Street St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Lasdin

6-DATE OF BIRTH (month, day and year)

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Baltimore

15- ROBERT R. KRAUTER, Burial Permit Clerk.

JAN 17 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 16/24

17- I HEREBY CERTIFY, That I attended deceased from November, 1923, to Jan. 15th, 1924 that I last saw h[illegible] alive on [illegible], 19..... and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senes

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Weiss, M. D.

1-16-1924 (Address) 30 S B'way

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Southern — DATE OF BURIAL, Jan 17 1924

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 82800

CERTIFICATE OF DEATH.

31 D 82800

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 961 Bennett Place ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Wm. Sotherley

(a) RESIDENCE NO. 961 Bennett Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Bonnie Sotherley

6 DATE OF BIRTH (month, day, and year) Oct 19th 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe-fitter

(b) General nature of industry, business, or establishment in which employed (or employer) O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Edgecomb Sotherley

11 BIRTHPLACE OF FATHER (city or town) Falmouth (State or country) England

12 MAIDEN NAME OF MOTHER Emma Jane Tomkins

13 BIRTHPLACE OF MOTHER (city or town) Falmouth (State or country) England

14 Informant John Joseph Sotherley (Address) 961 Bennett Place

15 Filed JAN 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1924, to Jan. 15, 1924, that I last saw him alive on Jan 14, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Osborne M. D.

, 19 (Address) 1211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1-18-1924
20 UNDERTAKER Henry C. Browning Sons	ADDRESS 51 W. Saratoga St

Body at Mercy Hospital, Morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82801

CERTIFICATE OF DEATH.

4 74-00 D 82801

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brooks

(Residence in Baltimore: No. 703 Raborg St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colr

5-Single, Married, Widowed, or Divorced, (Write the word.): Don't Know

6-DATE OF BIRTH, ... Don't Know ....., 1..... (Month) (Day) (Year)

7-AGE: Abt 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer): 08

9-BIRTHPLACE, (State or Country): U S

PARENTS.

10-NAME OF FATHER, U S

11-BIRTHPLACE OF FATHER, (State or Country), U S

12-MAIDEN NAME OF MOTHER, U S

13-BIRTHPLACE OF MOTHER, (State or Country), U S

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Morgue

15- JAN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 3 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

1-16 1924 (Address) [illegible]

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL DATE OF BURIAL JAN 17 1924

20-UNDERTAKER, Commissioner Health, ADDRESS

Dup. Wm. K. WOOBLE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82802

CERTIFICATE OF DEATH.

- 49

D 82802

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 257 Patapsco St. Westport 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Vanskiver

(a) Residence No. 257 Patapsco St. Westport Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Vanskiver

6-DATE OF BIRTH (month, day and year): May 4-1840

7-AGE: 83 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Brickmaker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 20 yrs

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Pennsylvania

PARENTS.

10-NAME OF FATHER: Charles Vanskiver

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Robert Vanskiver Jr.

(Address) 257 Patapsco St.

JAN 7 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 10, 1923, to Jan 15, 1924, that I last saw h... alive on Jan 14, 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(Duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Emmart M. D

1/16, 1924 (Address) 517 Hudson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Jan. 18, 1924
20-UNDERTAKER.	**ADDRESS**
Nelson E. Stiles	320 Md. Ave Westport

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82803

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Runnore Av ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt. A. Menendez Jr

(a) RESIDENCE. No. 2105 Runnore Ave ST. ..... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 25-23

7 AGE — Years 4 Months 24 Days

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robt Menendez

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Orleans La

12 MAIDEN NAME OF MOTHER Delia Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cabrit Co Md

14 Informant Father-Robert A. Menendez.

(Address) 2105 Runnore Ave.

15 Filed JAN 17 1924, 19 ... Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1924, to Jan 16th, 1924, that I last saw h... alive on Jan 15th, 1924, and that death occurred, on the date stated above, at 6 a ... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Benj Duvernay, M. D.

1/16 1924 (Address) 4001 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Central Cemetery Colvert Co. Md.

DATE OF BURIAL: Jan. 18th 1924

20 UNDERTAKER: Charles J. Schwab.

ADDRESS 585 N. Monroe St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82804

CERTIFICATE OF DEATH.

74001 ✓ D 82804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 Hayford ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry - N. Riley

(a) RESIDENCE NO. 1835 Hayford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Honora Riley

6 DATE OF BIRTH (month, day, and year): 1/31 1861

7 AGE: Years 63 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): own.

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: William Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt.

12 MAIDEN NAME OF MOTHER: Mary Russell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt.

14 Informant: Mrs. M. Lorbe.

(Address) 1835 Hayford Ave

JAN 17 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 15, 1924, that I last saw him alive on Jan 14, 1924, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Fritz J Kinzer M. D.

1/16, 1924 (Address) 27000 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery.

DATE OF BURIAL: Jan 18 1924

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1135 Hayford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82805

100-901 ✓ 82805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2101 E. Fayett St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Crawford

(a) Residence No. 2101 E. Fayett St. Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	W.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 11 1921

7-AGE. 2 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Charles Crawford.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Marian R. Sullivan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto.

14- (Informant) Charles Crawford
(Address) 2101 E. Fayette St.

15- [illegible] Harrison,
Registrar.

JAN 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 17-24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5 1924 to Jan 18 1924
that I last saw him alive on Jan 16 1924
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:

Pneumonia
Bronchial

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

Jan 16 1924 (Address) 2758 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel 1-19 1924 — DATE OF BURIAL.

20-UNDERTAKER, Wm Cook — ADDRESS 502 Nave

A—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Primary

Spec.—1-10-21 M&T 1500 Mks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82806

CERTIFICATE OF DEATH.

89 D 82806

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 15 WARD)

2-FULL NAME John Lee Walz

(a) RESIDENCE No. 2128 Mt. Holly ST., City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Hettie Walz

6 DATE OF BIRTH (month, day, and year) 10-28-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	58	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist. 025

(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins Hosp.

(c) Name of employer Johns Hopkins Hosp.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Walz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary S. Ives

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Record. (Address) JOHNS HOPKINS HOSPITAL

15 Filed Jan 17 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 16, 1924, that I last saw him alive on Jan 16, 1924, and that death occurred, on the date stated above, at 8-05 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 16, 1924

Was there an autopsy? Sympathectomy

What test confirmed diagnosis?

(Signed) R. L. Faulkner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Jan 19 1924

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AN 17 1924

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82807

CERTIFICATE OF DEATH.

49 D 82807

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 W. Pratt ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Rachel J. Risse

(Residence in Baltimore: No. 1606 W. Pratt St.; 70 yrs., 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 4 (Day), 1853 (Year)

7-AGE, 70 yrs. 6 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, James Sheldon

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER Rachel Mason

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sarah Risse

(Address) 1606 W. Pratt St. Balto.

15-

Filed JAN 17 1924, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 15 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1921, to Jan. 15 1924, that I saw her alive on Jan 15 1924, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right Kidney and bladder

(Duration) 2 yrs. 6 mos. 25 ds.

CONTRIBUTORY (Secondary) Hemorrhage of right Kidney (Duration) 2 yrs. 6 mos. 25 ds.

(Signed) Frances A. Carpenter M. D.

Jan 16, 1924 (Address) 2101 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan. 18, 1924

20-UNDERTAKER Margaret E. Hagan — ADDRESS 1422 Light St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82808

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3623 old York Road St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Reilley

(a) Residence No. 3623 old York Road St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine E. Reilley

6-DATE OF BIRTH (month, day and year) Dont Know.

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Mfg.

(c) Name of employer P. C. & K. Precesmore.

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER Michael

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Crowley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14-

(Informant) Katherine E. Reilley

(Address) 3623 Old York Road

15-

Filed Jan 17 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 12, 1924 to Jany 15, 1924 that I last saw him alive on Jany 15, 1924, and that death occurred, on the date stated above, at 12.25 A m.

The CAUSE OF DEATH* was as follows:

Hypertrophy and Enlarged heart

Dont Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Costello M. D.

, 19 (Address) 335 E. 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 1/19, 1924

20-UNDERTAKER, Chas. G. Davidson

ADDRESS 1111 W. Mt. Royal Ave

JAN 17 1924

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82309

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327½ N. Fulton Ave ST., 15 WARD)

2-FULL NAME Fannie C. Wiener

(a) RESIDENCE NO. 1327½ N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Chas. J. Wiener

6 DATE OF BIRTH (month, day, and year): June ? 1848

7 AGE: Years 75 | Months - | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Frances N. Rouse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Susan Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Edw. Rouse (Address) 1802 N. Fulton Ave

15 ... Registrar

AN 17 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1924

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 16, 1924, that I last saw her alive on Jan 15, 1924, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) O. M. Dewall, M. D.

1/16, 1924 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: Jan 19 1924

20 UNDERTAKER: N. J. Tickner & Sons ADDRESS: N. Pa.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82810

CERTIFICATE OF DEATH.

D 82810

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 N. Calhoun St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luranda Lee

(a) RESIDENCE. NO. 1519 N Calhoun ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William H. Lee

6 DATE OF BIRTH (month, day, and year) 7/25/82

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Powellsville N. C.

PARENTS

10 NAME OF FATHER James Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Halifax N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Irene Lewis
(Address) 1519 N. Calhoun St

15 Filed JAN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Jan 17, 1924, that I last saw her alive on Jan 17, 1924, and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marcella E. Tony, M. D.

, 19 (Address) 1751 Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Dr.	Jan 21 1924
20 UNDERTAKER	ADDRESS
Simmons & Mansfield	364 Mary

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82811

101-001

D 82811

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 33rd St Eastern Ave ST., 26 WARD)

2-FULL NAME Gustav Frank

(a) RESIDENCE NO. 33rd St & Eastern Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred, Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Frank

6 DATE OF BIRTH (month, day, and year) Sept 13th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) O&S
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John H. Frank

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Edwin Frank
(Address) 33rd St. & Eastern Ave

15 JAN 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 week yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

(Signed) Thos. B. Barton M. D.
(Coroner)

Jan 17th 1924 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Inatitutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 18 1924
20 UNDERTAKER	ADDRESS
Jno C. Miller	2334 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82812

CERTIFICATE OF DEATH.

100-500

D 82812

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Max Mark

(a) RESIDENCE NO. 1228 Hollins ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1434 E Baltimore

15 Filed JAN 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 17, 1924, that I last saw him alive on Jan 17, 1924 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: Bronchial asthma

(duration) 6 yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia Chronic Dil. Heart (duration) yrs. mos. 12 Ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) J. Harry Ulrich, M. D.

, 19 (Address) 11 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Jan 18 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1434 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82813

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 82813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Hebrew Home for Aged St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isidore Fuxman

(a) Residence No. 2100 E. Baltimore Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE	If LESS than 1 day
45 yrs. — mos. — ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Peddler
(b) General nature of industry, business, or establishment in which employed (or employer): D.G.
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis
(Address) 1439 E. Balto St

15- Filed JAN 8 1924 By ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 17-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 23, to Jan 17, 1924, that I last saw h.s. alive on Jan 16, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Levinson, M. D.

Jan 17, 1924 (Address) 1810 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Hebrew Mt Carmel	Jan 18, 1924
20-UNDERTAKER	ADDRESS
Jack Levis	1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every should be carefully supplied. AGE should be stated E in plain terms, so that it may be properly classified. instructions on back of certificates. CAUSE OF DEATH is very important. See

D 82814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Mercy Hospital or in case from Balto. County, St., 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John D. Blackston

(Residence in Baltimore: No. 111 Watson St. St.; yrs., 13 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1888 (Year)

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Con. Gas & E. Co.

9-BIRTHPLACE, (State or Country) St Marys Co. Md

PARENTS.

10-NAME OF FATHER. Marion Blakston

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Jenkinson

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Blackston

(Address) 111 Watson St

15- JAN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Jan 14 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas asphyxiation accidental (Gas meter in room)

Few minutes (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

Jan 16 1924 (Address) 16 E. Lexington

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Jan 19 1924
20-UNDERTAKER.	ADDRESS
Chas. L. Johnson	418 N. Arlington Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 82815

101-001

D 82815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 N. Vincent St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Stewart

(a) RESIDENCE NO. 1026 N. Vincent St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WHITE BIRTHS, WHETHER LEGITIMATE OR ILLEGITIMATE, AND COLORED LEGITIMATE BIRTHS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer (General)

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Ruth Sutton
(Address) 1027 N. Carrollton

15 Filed JAN 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Jan. 18, 1924 (Address) 2802 Elmhamer Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Jan 18 1924

20 UNDERTAKER Chas. H. Case Sons — ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82816

D 82816

CERTIFICATE OF DEATH.

90

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 N. Ellwood ave ST., 6 WARD)

2-FULL NAME Ellen King

(a) RESIDENCE No. 319 N. Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Michael King

6 DATE OF BIRTH (month, day, and year) Sept 15 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McBurnan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Alexander King

(Address) 319 N. Ellwood ave

15 JAN 18 1924 ROBERT E. KRAUS Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-11-24, 19..., to 1-14-24, 19...

that I last saw h[illegible] alive on 1/13 19...

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Traver, M. D.

1-11 19... (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cemetery — DATE OF BURIAL 1/18/ 1924

20 UNDERTAKER J. A. Moran — ADDRESS 3rd & E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82817

CERTIFICATE OF DEATH.

160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Bentlou ST., 16 WARD)

2-FULL NAME Rosario Fertitta.

(a) RESIDENCE NO. 835 Bentlou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-30-25

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
X			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City.
(State or country)

PARENTS

10 NAME OF FATHER ~~Frank~~ Fertitta.

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Filzpatrick

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Rosario P. Fertitta
(Address) 535 Bentlou St

t5 JAN 18 1924

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-15-, 1924, to 1-17, 1924.

that I last saw h[illegible] alive on 1-16-, 1924,

and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Con genital debility -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Insanity

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) S. Demarco M. D.

(Address) 1607 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cty.

DATE OF BURIAL 1/18 1924

20 UNDERTAKER John. A. Moran

ADDRESS 3000 E Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

on Back. 2 & 11 & 24 Book 7

D 82818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 82818

Registered No.....

1-PLACE OF DEATH 2707 North Calvert

City of BALTIMORE: (No.....St., 12 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Townsend

(a) Residence No. 2707 N. Calvert St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick W Townsend

6-DATE OF BIRTH (month, day and year) Jan 28, 1849

7-AGE, 74 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.....

037

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Richard Humphries

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Jane Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Frederick W Townsend

(Address) 2707 No Calvert St

15- JAN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1924 to Jan 17 1924 that I last saw h.. alive on Jan 17 1924 and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Lab. Endocarditis

Autumn

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Autumn

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Jefferis Dunbar M. D

4/18/ 1924 (Address) 2846 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL, Jan 19, 1924

20-UNDERTAKER Wm Cook ADDRESS 502 E Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated. OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82819

CERTIFICATE OF DEATH.

90 D 82819

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward T. Hayes

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1850

7-AGE. 73 yrs. mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer). 86

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Hayes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Elizabeth Flunt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed JAN 18 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 10 1924 to January 16 1924 that I last saw him alive on January 15 1924 and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Emphysema

Chronic Bronchitis

Chronic Myocarditis 9

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Hines, M. D

1-16-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	1/19, 1924

20-UNDERTAKER. ADDRESS

Fred A Tarby Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

82820

Registered No. 82820

1-PLACE OF DEATH

City of BALTIMORE: (No. 2309 W. North Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Holberg

(a) Residence No. 2309 W. North Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Female	White	Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) —— 1863

7-AGE.	If LESS than 1 day,
60 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Germany.

PARENTS.

10-NAME OF FATHER Ferdinand Holberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12-MAIDEN NAME OF MOTHER Esther Hoffman.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14- (Informant) Mr. David Holberg

(Address) 2309 W. North Ave.

15- Filed JAN 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1/17/24.

17- I HEREBY CERTIFY, That I attended deceased from Octob 1923, to Jan 16 1924, that I last saw h[illegible] alive on Jan 16 1924, and that death occurred, on the date stated above, at 12[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Hypertension

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan J. Holberg M. D

1/17/ 1924 (Address) 2306 W. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Hebrew Cem.	1/18/ 1924.

20-UNDERTAKER. David Sondheim ADDRESS 118-28 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, with ink. ONE space for each letter. All questions should be carefully answered. If unknown, "unknown" should be stated. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82821

CERTIFICATE OF DEATH.

4 D 82821

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Caton Ave ST. 9 WARD)

2-FULL NAME Elizabeth L Collins

(a) RESIDENCE NO. 718 Caton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John J. Collins

6 DATE OF BIRTH (month, day, and year) Jan 28 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House 037

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Carberry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Collins

(Address) 718 Caton ave

15 JAN 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 16, 1924, that I last saw h-- alive on Jan 15, 1924, and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection of Lungs

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) J. A. Ekland, M. D.

Jan 17 1924 (Address) 40 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Jan 19 1924

20 UNDERTAKER J. C. Wiedefeld — ADDRESS 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Groosche

D 82822 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 82822

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1107 South St. 21 St., Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida H. Groosche

(Residence in Baltimore: No. 1107 South St. St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Mar'd

6-DATE OF BIRTH: Oct (Month) 22 (Day) 1856 (Year)

7-AGE: 67 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Gust Kalschuer

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Wedelstaers

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustav Groosche

(Address) 1107 South St

15- JAN 18 1924

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 17 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

a few hours (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Duct Bowel

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. D. Paparah M. D. (Coroner.)

1-18 1924 (Address) 1107 Hanover St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL: Western Cem DATE OF BURIAL: Jan 19 1924

20-UNDERTAKER: Mrs Mrs J W Jenkins Son ADDRESS 801 W. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82823

CERTIFICATE OF DEATH.

90 D 82823

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1743 Carswell ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Zimmerman

(a) RESIDENCE NO. 1743 Carswell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mr Emma R. Zimmerman

6 DATE OF BIRTH (month, day, and year) Oct 2 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	65	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of Industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Joseph Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Miss. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Emma R. Zimmerman

(Address) 1743 Carswell St

JAN 18 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch, 1923, to Jan 16, 1924.

that I last saw him alive on Jan 16 1924

and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Aortitis (Organic Heart Disease)

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fritz J Kinzer, M. D.

1/7, 1924 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan. 19 1924

20 UNDERTAKER Henry Hauck Son — ADDRESS 1307 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82824

CERTIFICATE OF DEATH.

47 D 82824

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 813 N. Central Ave ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angeline Zimmerman

(Residence in Baltimore: No. 813 N. Central Ave. St.; 14 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 18 (Day), 1849 (Year)

7-AGE, 74 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Mr Remington

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wallace Zimmerman

(Address) 813 N. Central Ave

15-

Filed....., 191.....

ROBERT B. KRAUTER, Burial Permit Clerk.

JAN 18 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 18 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1923, to Jan 18 1924,

that I saw her alive on Jan 17 1924,

and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

.....

Carcinoma of Left breast

.....

..... (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastatic carcinoma

Stomach (Duration) yrs. 5 mos. ds.

(Signed) C. Rea Hartman M. D.

1/18/, 1924 (Address) Mapleton Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan. 19.... 1924

20-UNDERTAKER Henry Hoech Son

ADDRESS 301 E. Eager

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 82825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2 Second & Southern Ave at Woodlawn St., 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Neal

(Residence in Baltimore: No. 1716 Druesin St. St.; 30 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1867 (Year)

7-AGE: 55 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 010

9-BIRTHPLACE, (State or Country): Da

PARENTS.

10-NAME OF FATHER: Peter Blackwell

11-BIRTHPLACE OF FATHER, (State or Country): Da

12-MAIDEN NAME OF MOTHER: Mary Costin

13-BIRTHPLACE OF MOTHER, (State or Country): Da

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. A. Elliott

(Address) 1925 Ashland Ave

15-

JAN 18 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan (Month) 15 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison M. D.
(Coroner)

Jan 17 1924 (Address) 3632 Roland Ave

*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cemetery DATE OF BURIAL: Jan 18 1924

20-UNDERTAKER: Mrs. R. A. Elliott ADDRESS 1925 Ashland Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82826

82826

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 N. Durham ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida E. Elm

(a) RESIDENCE No 1016 N. Durham ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov. 27th. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Leland Elm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Meredith Cple

13 BIRTHPLACE OF MOTHER (city or town) (State or country) va.

14 Informant Meredith elm
(Address) 1016 N. Durham St.

15 Filed JAN 18 1924 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan17/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Brochopneumonia (Primary)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) J. S. Haller, M. D.
(Coroner.)

Jan 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Jan 18 1924

20 UNDERTAKER Mrs. R. C. Elliott — ADDRESS 225 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82827

CERTIFICATE OF DEATH.

9 112

D 82827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N. Spring St ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Miller

(a) RESIDENCE NO. 1812 N. Spring St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Miller

6 DATE OF BIRTH (month, day, and year) Apr 10/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) King William Co. Va.
(State or country)

PARENTS

10 NAME OF FATHER Fleming Thornton

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14
Informant Mary Nelson (sister)
(Address) 526 N. Bond St

15
Filed ....., 192.... ROBERT N. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Indigestion

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Ellis, M. D.
(Coroner.)

Jan 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Jan 21 1924
20 UNDERTAKER	ADDRESS
Geo. R. G. Elliott	1725 Eastlandave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

22 D 82828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 S. 12th ST., 26 WARD)

2-FULL NAME Walter Sherwood Camp

(a) RESIDENCE No. 313 S. 12th ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 0 yrs

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Stanley Camp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Texas

12 MAIDEN NAME OF MOTHER Lilly Francis Sparkes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant James S. Sparkes
(Address) 313 S. 12th St.

15 Filed JAN 18 1924 CHERI H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Jan 17, 1924, that I last saw him alive on Jan 16, 1924, and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Poliomyelitis.

(duration) yrs. mos 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Frank A. Glantz, M. D.

Jan 17, 1924 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Jan. 18 1924
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82829 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 82829

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 E. 29th St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Clark

(a) Residence No. 614 E. 29th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND ~~or (of) WIFE~~ of David Clark

6-DATE OF BIRTH (month, day and year) June 10, 1860

7-AGE. 63 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) James G. Dunphrey

(Address) 614 E. 29th St

15-

Filed JAN 18 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 17-24.

17- I HEREBY CERTIFY, That I attended deceased from Sept — 1923, to Jan 17 — 1924, that I last saw h[illegible] alive on Jan 16 1924, and that death occurred, on the date stated above, at 2.40 a m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy & Chronic Nephritis (Duration) — yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) M Bernard Hoch, M. D

Jan 17, 1924 (Address) 626 N. Calvert St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London Park Cem	Jan 19 1924
20-UNDERTAKER, George J Smith	ADDRESS 1532 Hollins St.

N. B.—WRITE PLAINLY, with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82830

51

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 E. Biddle ST., 8 WARD)

2-FULL NAME William O. Sapp

(a) RESIDENCE No. 1620 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel O. Sapp

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth A. Barbacie

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Daniel O. Sapp (Address) 1620 E. Biddle St.

15 Filed JAN 8 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924, to Jan 15, 1924, that I last saw h[illegible] alive on Jan 15, 1924, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo L Young M. D.

19 (Address) 1107 Eutaw Pl. Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	Jan 19 1924

20 UNDERTAKER — ADDRESS

Mrs Albert E. Fuller — 4806 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

Eusey.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 82831 113 D 82831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2342 Madison St., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Turner Eusey

(a) RESIDENCE No. 2342 Madison St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 '22

7 AGE Years 1 Months 5 Days 22 If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond M Eusey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma M Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Raymond M Eusey (Address) 2342 Madison Ave

15 JAN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Jan 16, 1924, that I last saw h— alive on Jan 15, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James F. McAuley M. D.

1/18, 1924 (Address) 1729 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Jan 19th 1923

20 UNDERTAKER J. Jones ADDRESS 111 S. Edmon St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82832 ✓ 49 D 82832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 E. Fort Ave ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Busick

(Residence in Baltimore: No. 414 E. Fort Ave St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed.

6-DATE OF BIRTH, January 23, 1860 (Month) (Day) (Year)

7-AGE, 63 yrs. 11 mos. 24 ds.

If LESS than 1 day. ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Housework)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, ? Ellicott

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER ? Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Busick

(Address) 704 E. Fort Ave.

15- JAN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 16, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1923, to Jan. 16 1924, that I saw h— alive on Jan. 15 1924, and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia of right lung

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. S. Marr M. D.

1.17., 1924 (Address) 801 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, W. P. Carmel Cemetery

DATE OF BURIAL, 1/18, 1924

20-UNDERTAKER E. J. Fanning & Son

ADDRESS 1460 Battery Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D 82833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-002 D 82833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 N. Hilton ST.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christina Junes.

(Residence in Baltimore: No. 1625 N. Hilton Str. St.; 10 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, April 25th (Month) (Day), 1846 (Year)

7-AGE, 77 yrs. 9 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), New York City N. Y.

PARENTS.

10-NAME OF FATHER, Conrad Abelman

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Louis Schoenijahn

(Address) 1625 N. Hilton Str.

15 Filed JAN 18 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 17th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1923, to Jan. 15th 1924, that I saw her alive on Jan 15 1924, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis.

(Duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Isaac C. Dickson M. D.

Jan. 18, 1924 (Address) 3055 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New York City	Jan. 18, 1924
20-UNDERTAKER Fos Foerderer Son	ADDRESS 2178 Bcu

Spec.—1-10-21—M&T—1500 Bks.

82834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 82834

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 East ST., 5 WARD)

2-FULL NAME Samuel J Scott

(a) RESIDENCE NO. 210 East st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

5a If married, widowed, or divorced HUSBAND of Catharine Scott

6 DATE OF BIRTH (month, day, and year) Exact date unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5 4 appox			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 0 8 6

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Strausberger's dry goods store

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Catharine Scott (Address) 210 East St

15 JAN 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug ... 1923 to Jan 16 ... 1924.

that I last saw him alive on Jan 14 ... 1924,

and that death occurred, on the date stated above, at 6 PM m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma.

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical + symptoms

(Signed) RJ Ryan, M. D.

1/19, 1924 (Address) 1429 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Burial Ground — DATE OF BURIAL: Jan 20 1924

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA AND ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 82835

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Central Ave St., 5 WARD)

2-FULL NAME William A Henson

(a) RESIDENCE NO. 404 Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamster before going in the army

(b) General nature of industry, business, or establishment in which employed (or employer) since that time has been sickly

(c) Name of employer working irregularly

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Richard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sadie Smith (Aunt)

(Address) 404 Central Ave

ROBERT W. KNIGHT

15 JAN 1 81924 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17

I HEREBY CERTIFY, That I attended deceased from May, 1923, to Jan 16, 1924, that I last saw h live on Jan 14, 1924, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C D Young M. D.

1/7, 1924 (Address) 1729 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Albany cemetery — DATE OF BURIAL: Jan 20 1924

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 82836

D 82836 CERTIFICATE OF DEATH. Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Logan

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1876

7-AGE.	If LESS than 1 day.
47 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Louisiana

PARENTS.

10-NAME OF FATHER, Steve Logan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JAN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 15, '24

17- I HEREBY CERTIFY, That I attended deceased from January 9 19 24 to January 15 19 24, that I last saw him alive on January 15 19 24, and that death occurred, on the date stated above, at 11:45 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym

(Signed) Claude S. Hinman M. D

1-16-24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19....
HOPKINS HOSPITAL	
20-UNDERTAKER,	ADDRESS JAN 18 1924

N. B.—WHITE CERTIFICATES. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-21

Spec.—1-10-21—M&T—1500 Blks.

D 82837

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 82837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Patterson Pk ST. 21 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Waddell

(a) RESIDENCE NO. 1104 Warner ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE colored | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Lillian Waddell

6 DATE OF BIRTH (month, day, and year) Feb. 25, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thos Waddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Tinsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Information Given By (Address) Lillian Waddell 1104 Warner St

15 Filed JAN 18 1924 19.... ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/21, 1923 to Jan. 17, 1924.
that I last saw h— alive on Jan. 16, 1924
and that death occurred, on the date stated above, at 9:30A m.

The CAUSE OF DEATH* was as follows:

Interculosis of Lung
Several years (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tb. Peritonitis
about (duration) 6 mo yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Jan 8, 1924

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy findings

(Signed) C. C. Singleton M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Peterville Va | DATE OF BURIAL 1/18 19 24

UNDERTAKER Emmert & Stansbury | ADDRESS W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82838

CERTIFICATE OF DEATH.

113 D 82838

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 — Church ST., [illegible] WARD)

2-FULL NAME Vladislav Jamercy

(a) RESIDENCE NO. 2 - Church ST., 25 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
X	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Stanislav Jamercy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Paulina Pawlowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislav Jamercy (Address) 2 E Church

15 [illegible] ..., 19 Robert P. Harrison, Registrar

JAN 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1924, to Jan. 16, 1924, that I last saw him alive on Jan. 16, 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

.....

.....

.....

.....(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ... yrs. mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) William A. Leet, M. D.

Jan 17, 1924 (Address) 816 - Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Jan 18 1924
20 UNDERTAKER	ADDRESS
Fred Crockett	1906 East Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82839

CERTIFICATE OF DEATH.

100500 ✓

D 82839

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Chester ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Montalbano

(a) RESIDENCE. No. 514 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Montalbano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Joy Sala

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Thomas Montalbano (Address) 514 N Chester St

15 [illegible] 19 Robert P. Harrison, Registrar

AN 1 81924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17- 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-13-, 1924, to 1-17-, 1924, that I last saw him alive on 1-17-, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Double Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Signs.

(Signed) John C. Kato, M. D.

1-17-1924 (Address) 116 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 18 1924

20 UNDERTAKER Ford Brockton ADDRESS 1916 Baltard

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D 82840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 82840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Aliceanna ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Poplauski

(a) RESIDENCE NO. 1603 Aliceanna ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

Filed JAN 8 1924, 19

Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1924, to Jan. 17, 1924, that I last saw him alive on Jan. 16, 1924, and that death occurred, on the date stated above, at 3 30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (left lung completely consolidated)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ford. A. Ries, M. D.

, 19 (Address) 24 S. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Jan 19 1924

20 UNDERTAKER — ADDRESS

—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED PERMANENTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82841 45 D 82841

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 S Bouldin St., 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F Gillen

(a) RESIDENCE NO. 137 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Gillen

6 DATE OF BIRTH (month, day, and year) May - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Struct Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Gillen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cmaley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John Gillen 137 S. Bouldin St

15 JAN 8 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to Jan 17, 1924.

that I last saw her alive on Jan 16, 1924

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1923

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tillow M. D.

1/18, 1924 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 1/19/1924

20 UNDERTAKER J A Moran

ADDRESS 3dd E. Baltimore

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Beere)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82842

CERTIFICATE OF DEATH.

159 D 82842

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 S. Broadway St.; 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernadette Beene

(Residence in Baltimore: No. 128 S. Broadway St.; ....yrs.,....mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Single

6-DATE OF BIRTH, ...Jan.... (Month) ....9.... (Day) ....1924.... (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Leo J. Beene

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary V. McCarthy

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo Beene

(Address) 128 S. Broadway

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

JAN 18 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ...Jan.... (Month) ....18.... (Day), ...1924.... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1924, to Jan. 16, 1924, that I saw her alive on Jan. 17, 1924, and that death occurred, on the date stated above, at 6-50 a. m.

The CAUSE OF DEATH* was as follows:
Congenital malformation of alimentary Canal.

..... (Duration).....yrs.....mos. 9 ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration)....yrs.....mos.....ds.

(Signed) Eugene L. Peaslee 2nd M. D.

1-18-, 191... (Address) Ten Hills

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cemetery DATE OF BURIAL. January 18, 1924

20-UNDERTAKER John A. Mowen ADDRESS 1000 Baltic St.

1.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D 82843

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Gill

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital Records

(Address).....

15- Robert F. Harrison,
Filed ..... 192 ..... Burial Permit Clerk.

JAN 8 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-18-24

17- I HEREBY CERTIFY, That I attended deceased from 1-5 19 24 to 1-18 19 24.

that I last saw h. alive on 1-18 19 24

and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Senile Intermittus

Senile Dementia

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Drane M. D

1-18. 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Md

DATE OF BURIAL. Jan 20 19 24

20-UNDERTAKER, Ebenezer H. Sen

ADDRESS 3617 Chestnut Ave

Filed JAN 8 1924 Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 32841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 32844

CERTIFICATE OF DEATH.

100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2231 W. Pratt St., 20th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. F. Hallier

(a) Residence No. 2231 W. Pratt St., 20th Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Emilie M. Hellier

6-DATE OF BIRTH (month, day and year) April 5th 1870

7-AGE. 53 yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED. 045

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer.....

9-BIRTHPLACE (City or Town) (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER John A. Hellier

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER M. Trush

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-INFORMANT Emilie M. Hellier

(Address) 2251 W. Pratt St

15-FILED JAN 18 1924, 192.....

Robert P. Harrison. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 17/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1924 to Jan 17 19 24

that I last saw h. alive on Jan 16 19 24,

and that death occurred, on the date stated above, at 1.25 A. m.

The CAUSE OF DEATH* was as follows:

1. Foramed

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pulmonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harwood Lalen M. D.

1/7, 192 (Address) 2027 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. Jan 20 1924

20-UNDERTAKER. J. B. Hayfert ADDRESS 3316 Fleet Ave

JAN 18 1924

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

Spec.—1-10-21—M&T—1500 Bks.

D 82845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82845

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1079 W Lexington ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances A Hawkins

(a) RESIDENCE No. 1079 W Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Walter Hawkins

6 DATE OF BIRTH (month, day, and year): Sept 3. 1876

7 AGE: Years 47 | Months 4 | Days 13 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Claiborne Tinsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Martha Lowry 1079 W Lexington St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1922 to Jany 16, 1924 that I last saw h[illegible] alive on Jany 13, 1924 and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoides

(duration) 1 yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) W. T. Howell M. D.

19 (Address) 1198 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Jan. 19 1924

20 UNDERTAKER: Jno. M. Johnson

ADDRESS 1309 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDS, PHYSICIANS' AND UNDERTAKERS' REPORTS. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' information may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 82846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82846

CERTIFICATE OF DEATH.

41

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3126 E. Baltimore St.; 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ray Watson

(Residence in Baltimore: No. 3126 E Baltimore St.; 3 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 13, 1876 (Month) (Day) (Year)

7-AGE, 48 yrs. 8 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Elderton Penna.

PARENTS.

10-NAME OF FATHER, — McCracken

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benj H. Watson

(Address) 3126 E. Baltimore

15- JAN 18 1924 Robert P. Harrison, 191.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 — 17 —, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16- 1923 to Jan 17th 1924, that I saw her alive on Jan 16th 1924, and that death occurred, on the date stated above, at 7 30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Constipation Arthritis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pyo. Septicaemia

(Duration) yrs. 2 mos. ds.

(Signed) J. F. Heesman M. D.

1-18-, 1924 (Address) 1919 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Elderton Penna. DATE OF BURIAL, 1/18....., 1924

20-UNDERTAKER John A. Moran ADDRESS 3000 E. Baltimore St.

VIA P. R. R. Benj H. Watson pas. in charge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82847

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D 82847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pearson

(a) RESIDENCE NO. St. Agnes Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day and year) Jan. 15. 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2 days				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Agnes Hosp Balto Md

PARENTS

10 NAME OF FATHER Charles Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Cora ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa.

14 Informant Mrs. Cora Pearson

(Address) Blue mont, Mockton, Md

15 Filed JAN 18 1924 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1924, to Jan. 17, 1924

that I last saw her alive on Jan. 17, 1924, and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Prolonged labor, due to contracted pelvis.

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Increased intra-cranial pressure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Caesarean Section (Mother) Date of 1-15-24

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Dudley P. Bowe M. D.

, 19 (Address) 904 - N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Melvale - Elkridge	Jan 19 1924
20 UNDERTAKER	ADDRESS
E Le Roy Stiffler	425 North

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 82848

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 S. Broadway ST., ✓ WARD)

Johns Hopkins Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Gryszka

(a) RESIDENCE NO 735 S Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Gryszka

6 DATE OF BIRTH (month, day, and year) Aug 31/1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Near-beer

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Casimab Gryzska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Irene Cymbor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant George Gryzska

(Address) 735 S. Briadway

15 Filed ....., 192 Robert P. Harrison, Registrar

JAN 18 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Culler, (Coroner) M. D.

Jan 18/24 (Address) 508 E. North Ae

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 21 1924
20 UNDERTAKER	ADDRESS
John A Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82849

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Thornton

(a) Residence No. 632 E. 28th St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Percy C Thornton

6-DATE OF BIRTH (month, day and year) May 3, 1870

7-AGE. 53 yrs. 8 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland Baltimore

PARENTS.

10-NAME OF FATHER, James Hale

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER, Jennie Chandler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

11- (Informant) Municipal Hospital Records

(Address)

15- Filed JAN 16 1924 E. L. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-18-24

17- I HEREBY CERTIFY, That I attended deceased from 1-15 1924 to 1-18 1924

that I last saw her alive on 1-17 1924

and that death occurred, on the date stated above, at 12 40 m.

The CAUSE OF DEATH* was as follows:

Obesity

Hypertension

Chronic nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude S. Thomas M. D

1-18, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Loudon Park

DATE OF BURIAL, Jan 21 1924

20-UNDERTAKER. W. H. Cook

ADDRESS 332 E Lafayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

) 82850

CERTIFICATE OF DEATH.

44 82850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Ettting ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jenkins

(a) RESIDENCE NO. 1823 Ettting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of Cyrus Jenkins

6 DATE OF BIRTH (month, day, and year) Month 4 May 3 1858

7 AGE: 65

Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of Industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Mr. Ged West (son in law) 1823 Ettting St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

JAN 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1923, to Jan 16, 1924, that I last saw h[illegible] alive on Jan 15, 1924, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(Probably Carcinoma)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) R J [illegible], M. D.

1/18, 1924 (Address) 1424 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 1-20 1924

20 UNDERTAKER: George H. Gibson

ADDRESS: 1733 Druid Hill Ave

F. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gall Bladder

Spec.—1-10-21—M&T—1500 Bks.

D 82851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82851

CERTIFICATE OF DEATH.

74001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 E Fairmount ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Teresa Gorsuch

(a) RESIDENCE NO. 711 E. Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Louis C Gorsuch.

6 DATE OF BIRTH (month, day, and year): Nov. 2/1845

7 AGE: Years 75 Months 2 Days 14 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt.

PARENTS

10 NAME OF FATHER: Andrew Geis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary T. Geis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Edward Gorsuch

(Address) 711 E. Fairmount st

15 Filed JAN 9 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/16/24 19

17 I HEREBY CERTIFY, That I attended deceased from December 1 19 22 to January 16 19 24.

that I last saw her alive on January 16 19 24

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

1 (duration) 1 yrs. 1 mos 16 da.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analysis

(Signed) P E Jelli, M. D.

Jan 19 24 (Address) 818 E. Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Country.

DATE OF BURIAL: Jan. 18 1924

20 UNDERTAKER: George F. Rust.

ADDRESS: 1735 Harford Av

N1

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82852

CERTIFICATE OF DEATH.

D 82852

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 N. Lafayette Ave ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Spencer

(a) RESIDENCE NO. 1506 N. Lafayette Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Spencer

6 DATE OF BIRTH (month, day, and year) 2/12/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Bernard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Lee

(Address) 2739 Pressbury St

15 Robert P. Harrison, Registrar

JAN 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Jan 17, 1924, that I last saw him alive on Jan 16, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas A. Todd, M. D.

1/17, 1924 (Address) 735 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Jan 21 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford Ave

B.—WRITE PLAINLY, WITH UNFADING INK ... mation should be carefully supplied. AGE sh... CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on b... ...GE should be stated EXACTLY. PHYSICIANS ... that it may be properly classified. Exact statement of OCC... ...s on back of certificates.

Spec.-1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16926 ✓

16 82853

CERTIFICATE OF DEATH. X 74-D 32853

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Williams

(a) RESIDENCE NO. Monkton Md ST., ... WARD Monkton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: David Williams

6 DATE OF BIRTH (month, day, and year): Unknown 1871

7 AGE: Years 52 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS.

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 JAN 19 1924 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1924 to Jan 17 1924.

that I last saw her alive on Jan 17 1924.

and that death occurred, on the date stated above, at 5 25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

(duration) ..... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Monkton Md

DATE OF BURIAL: Jan 20 1924

20 UNDERTAKER: Joseph A Farrell

ADDRESS 2319 Druid

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82854

CERTIFICATE OF DEATH.

D 82854

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3351 Beech Ave ST., 13 WARD)

2-FULL NAME Lucy Ellen Sherman

(a) RESIDENCE NO. 3351 Beech ave ST.
(Usual place of abode)

WARD .....
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7/1858.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Linbs. Sherman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Day.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Flora Davis 2nd
(Address) 3356 Beech ave Balto

Robert P. Hartsch,
Burial Permit Clerk. Registrar

15 JAN 19 1924, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923, to Jan 17, 1924 that I last saw h.. alive on Jan 17, 1924 and that death occurred, on the date stated above, at 8:03 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,
Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis Congestion of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Blood

(Signed) Fred Walter Denby, M. D.

1/17, 1924 (Address) 2321 Dalrymple

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leister Grove Cemetery Mt Jackson, Va

DATE OF BURIAL 1/21 1924

20 UNDERTAKER J. WALTER DAVIS, FUNERAL DIRECTOR 2nd

ADDRESS 2307 Paine St

...GE should be stated EXACTLY. PHYSICIANS should state ... AGE. ... at it may be properly classified. Exact statement of OCCUPA- ... s on back of certificates. ... TION is very important. See instructions on back.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82855

CERTIFICATE OF DEATH.

185

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 South 11th St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy D. Walter

(a) Residence No. 9 S 11th St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 22 1922

7-AGE, 1 yrs. 2 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Edgar P. Walter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Katherine A. Preis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimo

14- (Informant) Edgar P. Walter

(Address) 9 South 11th St

15- Filed JAN 9 1924, 192.

Robert P. Harrison, Registrar.

Burial Permit Clerk.

ORDER FOR BALTIMORE CITY—EASTERN DIST. No. 105.

Joseph L. Valentine M.D. 14 S. Broadway

[X] MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 17 24

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 17, 1924, that I last saw h[illegible] alive on Jan 17, 1924, and that death occurred, on the date stated above, at 7.10 P.m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

.....(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Accident (Fall)

.....(Duration) .....yrs. .....mos. .....ds.

over

17-Where was disease contracted if not at place of death? .....

Did an operation precede death? .....Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M.D.

18, 1924 (Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Schwartz — DATE OF BURIAL, 1/19, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Nor[illegible]

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway [illegible]dent; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Accidentaly fell from Chair

Spec.—1-10-21—M&T—1500 Bks.

D 82856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82856

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Thompson

(a) RESIDENCE NO. 2317 North Charles St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Thompson

6 DATE OF BIRTH (month, day, and year) Mch. 24, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Amanda Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Stacy H. Thompson (Address) Community Records

15 Filed , 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1924, to Jan 18, 1924, that I last saw him alive on Jan 18, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricle & Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Blood analysis

(Signed) W Wallace Walker, M. D.

, 19 (Address) Community Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL*	DATE OF BURIAL
Druid Ridge Cem.	Jan 21 1924
20 UNDERTAKER	ADDRESS
John O. Whitehill	1201 N. Fayette St

N. B.—WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. CERTIFICATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82857

CERTIFICATE OF DEATH.

D 82857

1-PLACE OF DEATH University of Maryland Hospl REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Levy

(a) RESIDENCE NO. 623 S. Kenwood ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 28 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Ella Levy.

6 DATE OF BIRTH (month, day, and year): May 18th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Restaurant Proprietor.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Abraham Levy.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Hannah Braffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): University Hospital. Records.

15 Egbert P. Harrison, Registrar

JAN 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1924, to 16th Jan, 1924, that I last saw him alive on Jan 16th, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Incarcerated Inguinal Hernia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Jan 14th

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John M. Edmonds M. D.

(Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 19th 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4036 Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1418 Decatur St., Pk 90 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Wirner

(a) Residence No. 1418 Decatur St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Wirner

6-DATE OF BIRTH (month, day and year) August 3, 1868

7-AGE. 55 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) BOOKR

(c) Name of employer.....

9-BIRTHPLACE (city or town) Austria
(State or Country), Hungary.

PARENTS.

10-NAME OF FATHER, John Wirner

11-BIRTHPLACE OF FATHER (city or town) Austria
(State or Country), Hungary.

12-MAIDEN NAME OF MOTHER, Katherine Queens.

13-BIRTHPLACE OF MOTHER (city or town) Austria
(State or Country), Hungary.

14- (Informant) Max Wirner.

(Address) 1418 Decatur St

15- Robert P. Harrison, Registrar.

JAN 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 16 1924

17- I HEREBY CERTIFY, That I attended deceased from January 9 1924 to January 16 1924

that I last saw h.. alive on January 16 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

acute dilatation (Two hours)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma

1 at intervals.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos. A. Stevens, M. D

1/18, 1924 (Address) 2878 Hayward

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross.	Jan. 21, 1924
20-UNDERTAKER, C. A. Co Inc	ADDRESS
Chas. L. Stevens.	1501 E 70th St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 82859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82859

CERTIFICATE OF DEATH.

REGISTERED NO. 202

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 70 WARD)

2-FULL NAME Nathan Yoffie

(a) RESIDENCE No. 915 Gilmor ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-7-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Errand Boy
(b) General nature of industry, business, or establishment in which employed (or employer) in Printing Shop
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER David Yoffie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Chadkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto

15 Filed ..... 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract. skull caused by Stone Falling from Comide of Tenement Bldg.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) M. T. Riley (Coroner.) M. D.
Jan. 19. 1924 (Address) 1637 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Jan 20 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82860

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 E 20th ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Tridone

(a) RESIDENCE NO. 409 E 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER John Tridone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Castello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John Tridone (Address) 409 E 20th St

15 Filed ....., 19.... Robert P. Harrison, Registrar

JAN 1 91924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18th 19 24

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 19 24, to Jan 18th, 19 24, that I last saw h alive on Jan 18th, 19 24 and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Capillary bronchitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) diphtheria

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Testa, M. D.

, 19 (Address) 210 Pearl St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 19th 1924
20 UNDERTAKER George Schilling & Sons	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D 82861

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 841 W. 35th St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Albert Haines

(a) Residence No. 841 W 35th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maud R

6-DATE OF BIRTH (month, day and year) Feb 1878

7-AGE. 45 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Pa.

PARENTS.

10-NAME OF FATHER, Andrew Haines

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa.

12-MAIDEN NAME OF MOTHER, Trimmer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa.

14- (Informant) Maud R Haines

(Address) 841 W. 35th St

15- Robert P. Harrison, 192 Registrar.

JAN 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 17 24

17- I HEREBY CERTIFY, That I attended deceased from January 7, 1924 to Jan 17, 1924 that I last saw him alive on Jan 16, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbuncle of neck + Sepsis

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspection

(Signed) H. H. Stansbury M. D.

, 19 (Address) 714 Park Ave, Balto.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Meadow Branch Cemetery — DATE OF BURIAL. Jan 20, 1924

20-UNDERTAKER. N Maurice Poulton — ADDRESS 2238 N Monroe

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82862

CERTIFICATE OF DEATH.

D 82862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Fremont ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Miller

(a) RESIDENCE NO. 36 Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 23 1864

7 AGE: Years 59 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): Button Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank F. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Tresia Muth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Miller

(Address): 810 Fremont St

15 Filed JAN 19 1924. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1924. to Jan 17. 1924.

that I last saw him alive on Jan 17. 1924.

and that death occurred, on the date stated above, at 11.25 m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis Hepatis Chr Duodenal Ulcer

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Chronic Pericard (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Nitch, M. D.

1/19. 1924 (Address) 215 Chilkenson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Jan 23 19

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W. Fayette St

JAN 19 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82863

CERTIFICATE OF DEATH.

90

D 82863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ella Bosses for 19 ST., WARD)

2-FULL NAME Aged Women's Home

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1400 N Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md

PARENTS

10 NAME OF FATHER: Henry B Busted

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co

12 MAIDEN NAME OF MOTHER: Margaret Clagett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Md

14 Informant: Ella F Jones

(Address) 1400 N Lexington St Md Gen

15

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 18, 1924, that I last saw h alive on Jan 15, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Organic Diseases of Heart

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Howard, M. D.

June 19 24 (Address) 7374 Fayette W

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Davidsonville Annapolis Md	June 21 19 24
20 UNDERTAKER George J. Smith	ADDRESS 153 Hollins st

N 1 91924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE mation should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 82864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 82864

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Janey

(a) Residence No. 929 Park Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	Black	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of	?
6-DATE OF BIRTH (month, day and year)	1859
7-AGE, 65 yrs. mos. ds.	If LESS than 1 day, hrs. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

JAN 19 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 15, 1924

I HEREBY CERTIFY, That I attended deceased from January 11 1924, to January 15 1924,

I last saw her alive on January 14 1924,

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (secondary) Third degree Burns of body

Accidental (Duration) yrs. mos. 4½ ds.

Where was disease contracted if not at place of death? (over)

Did operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Fulton, M. D

1-15-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	Jan 19 1924

20-UNDERTAKER.	ADDRESS
Jas H Dennis	1303 Pressstman St.

POOR BALTIMORE CITY DISTRICT

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *scpticemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Clothes caught fire from coal stove.

Spec.—1-10-21—M&T—1500 Bks.

D 82865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82865

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1345 Carroll St. 21 WARD)

2-FULL NAME Baby Green

(a) RESIDENCE NO. 1345 Carroll ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11. 1924

7 AGE Years Months Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Evelyn Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Maryland

14 Informant (Address): Mother

15 Robert P. Harrison, Registrar

JAN 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Jan 18, 1924, that I last saw h[illegible] alive on Jan 18, 1924 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Umbilical Cord

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Williams Reese, M. D.

1-19. 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cy

DATE OF BURIAL: Jan 19 1924

20 UNDERTAKER: Braun & Freeland

ADDRESS 114 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82866

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1135 N. Mount ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dianah Davis

(a) RESIDENCE. No. 1130 N. Mount ST., WARD. Lynchburg S.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Davis

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Aaron Magazine

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C

14 Informant Thomas Davis

(Address) 1135 N. Mount St

15 Filed JAN 9 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Jan 18, 1924, that I last saw h.. alive on Jan 17, 1924, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Chron. Nephritis X

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General anasarca

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) Chas. C. Conser, M. D.

1/18, 1924 (Address) 1101 W Fulton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LEE CO S.C. Lynchburg SC	Jan 20 1924
20 UNDERTAKER	ADDRESS
C. H. Brown's Son	108 W Monty

JAN 9 1924

Should be stated EXACTLY. PHYSICIANS should be careful, and certificate carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82867

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 15 WARD)

2-FULL NAME Leon C. Wynants

(a) RESIDENCE No. 4606 Park Heights Ave ST., Baltimore.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Kate Wynants

6 DATE OF BIRTH (month, day, and year): June 29 - 1887

7 AGE: 36 yrs. 6 mos. 18 ds. If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chef

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Bordeaux - France

PARENTS

10 NAME OF FATHER: Chas. P. Wynants

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Emmette Hagspeau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Kate Wynant. (Address) 4606 Park Heights Ave

15 Registrar: Robert P. Harrison, Burial Permit Clerk.

N 1 9 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jan - 13, 1924 to Jan - 17, 1924 that I last saw h[illegible] alive on Jan - 17, 1924 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.
Myocardial Insufficiency

(duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary): Appendicitis

(duration) .... yrs. .... mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Jan - 14 - 24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical signs -

(Signed) [illegible], M. D.

, 19 (Address) Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: 1/21/1924

20 UNDERTAKER: Chas P. Evans & Son — ADDRESS: 1180 W. Mt Royal Ave

GE should be stated EXACTLY. PHYSICIANS should write
mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 82868

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D 82868

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Ruxton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry P. Marks

(Residence in Baltimore: No. 1721 Ruxton Ave. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, Oct 22, 1923 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 27 ds.

If LESS than 1 day. ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Sidney Marks

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Kera Buttenberg

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sidney Marks

(Address) 1721 Ruxton Ave

15- JAN 2 0 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 19, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan. 18, 1924, that I saw him alive on Jan. 18, 1924, and that death occurred, on the date stated above, at 4P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Bruce M. Mench M. D.

Jan 19, 1924 (Address) 2352 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Balto. Hebrew	1/20/, 1924
20-UNDERTAKER	ADDRESS
Baird Sondheim	178 W. Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82869

CERTIFICATE OF DEATH.

101-001 D 82869

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 E Madison ST., 10 WARD)

2-FULL NAME Elizabeth A Kirsch

(a) RESIDENCE No. 1108 E Madison ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 22nd 1860

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	60	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Frederick Kirsch

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Wilhelmina Kuntz

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Agnes Ward

(Address) 1108 E Madison St

15 Filed JAN 2 1924 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 18, 1924, that I last saw her alive on Jan 18, 1924, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Robert L. Green, M. D.

(Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 20th 1924

20 UNDERTAKER George Schilling & Sons — ADDRESS 1106 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

16764 Col 82870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 82870

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Myrtle Brown

(a) RESIDENCE NO. 3128 Dallas ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Blank	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Jan 2 - 1910

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
14	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Vincent Brown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Johnson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 JAN 2 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1923, to Jan 17, 1924, that I last saw h— alive on Jan 17, 1924, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Hereditary Syphilis (late)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Central Nervous System Syphilis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Burg, M. D.

19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 1/20 1924

20 UNDERTAKER Jas. W. Skinner

ADDRESS 1625 E. Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WHITE EITHER, WITH CONTRIBUTORY INFORMATION. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82871

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 N.Kenwood Ave. ST., 7 WARD)

2-FULL NAME Lottie M.Mueller,

(a) RESIDENCE No. 710 N.Kenwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov.17.1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	29	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (JW)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles A.Opel,Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila.Penna.

12 MAIDEN NAME OF MOTHER Lottie Swindell,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Charles A.Opel,Sr.
(Address) 710 N.Kenwood Ave.

15 JAN2 01924 ROBERT A. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1924, to Jan 19. 1924.

that I last saw h.e alive on Jan 19. 1924

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about 1 yr (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Of Lung

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) C. H. Meyer Jr, M. D.

1/19. 1924 (Address) 1638 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan.22 1924
20 UNDERTAKER Geo W Little	ADDRESS 2700 EDMONDSON AVE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82872

CERTIFICATE OF DEATH.

117 D 82872

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N. Gay ST., 3 WARD)

2-FULL NAME Howard K. Mallonee

(a) RESIDENCE NO. 2867 Penna Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore CO.MD.

PARENTS

10 NAME OF FATHER Ephriam Mallonee,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.Md.

12 MAIDEN NAME OF MOTHER Mary E.Ambrose,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.Md.

14 Informant Mary E.Mallonee, (Address) 2867 Pennsylvania Ave

15 Filed JAN 2 0 1924 HUBERT F. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-24

17

I HEREBY CERTIFY, That I attended deceased from 12-24-23, 19..., to 1-18-24, 19...,

that I last saw h alive on 1-18-24, 19...,

and that death occurred, on the date stated above, at 5-60 p m.

The CAUSE OF DEATH* was as follows:

{ Pneumonia Lobar - Broncho.
{ Acute appendicitis (suppurative)

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac Dil

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? M. G. Hospl.

Did an operation precede death? Yes Date of 12-24-23

Appendectomy - Harge

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Geo A Compton, M. D.

, 19 (Address) M G Gen Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill Md.

DATE OF BURIAL Jan. 21. 24

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lillie M. Smith

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82873

CERTIFICATE OF DEATH.

145-003

D 82873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lillie Smith

(a) RESIDENCE NO. 1712 Wilkins Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob H.Smith.

6 DATE OF BIRTH (month, day, and year) May 2.1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Corbin Sank,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Julia Walsh,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Jacob H.Smith,

(Address) 1712 Wilkins Ave

JAN2 01924

ROBERT E. KRAUTH, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-7, 1924, to 1-19, 1924

that I last saw her alive on 1-19, 1924

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of 1/18/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo A Tompkins, M. D.

, 19 (Address) MdGenHosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

DATE OF BURIAL Jan 22 1924

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 82874

90 D 82874

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Dumbarton Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles T. Wright

(a) RESIDENCE No 628 Dumbarton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sally M. Wright

6 DATE OF BIRTH (month, day, and year) Oct 15/1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

057

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. T. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ann Walstom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Andrew I. Wright
(Address) Ywi Dumbarton Ave

15 Filed ....., 192 ..... Registrar

JAN2 0 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilitation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senility (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Patterson, M. D. (Coroner.)

Jan 19/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 21 1924
20 UNDERTAKER	ADDRESS
C. A. Wiedefeld Jr	501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82875 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 3 D 82875

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Isabella Burgess

(a) RESIDENCE No. Pine Orchard Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record
(Address)

15 Filed JAN 20 1924 MARTIN H. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19/24

17

I HEREBY CERTIFY, That I attended deceased from Dec. 6, 19 23 to Jan 19, 19 24.

that I last saw her alive on Jan 19, 19 24

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Insufficiency (Rheumatic)

Tuberculosis (Pulmonary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) K. W. Gehr, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Howard Co Md	Jan 21 1924
20 UNDERTAKER Scott M. Davis	ADDRESS Ellicott City Md

N.B.—WRITE PLAINLY, with CHARCOAL PENCIL. AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A.

Spec.—1-10-21—M&T—1500 Blks.

Arnold

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 82876

CERTIFICATE OF DEATH.

100-001

D 82876

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Arnold

(a) RESIDENCE NO. 815 Lemmon St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f

4 COLOR OR RACE: Bl.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Peter Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Bertha Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): University Hospital Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/16 1924.

17

I HEREBY CERTIFY, That I attended deceased from 1/15, 1924, to 1/16, 1924,

that I last saw her alive on 1/16/24, 19—,

and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Bronco pneumonia

Intercurrent fever.

Uncertain. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rachitis, malnutrition

Uncertain. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Eudowood Sanitarium

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Jan 20th 1924

20 UNDERTAKER: E. Jones

ADDRESS: 1113 Gilmor St

JAN 21 1924

PHILIP A. BRAUER, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, with indelible pencil. AGE should be carefully supplied. AGE mation should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82877

CERTIFICATE OF DEATH.

23 D 82877

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hos. ST., 16 WARD)

2-FULL NAME George Woolford

(a) RESIDENCE NO. 1139 N. Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Woolford

6 DATE OF BIRTH (month, day, and year) May 31 - 94

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eugene Woolford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary E. Woolford

(Address) 1139 N. Stricker

15 JAN 20 1924 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1924.

17 I HEREBY CERTIFY, That I attended deceased from January 14 1924 to January 17 1924.

that I last saw him alive on January 17 1924.

and that death occurred, on the date stated above at 12.20 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Encephalitis Lethargica.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Scheurich M. D.

(Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Jan 19 1924

20 UNDERTAKER Sam'l W. Chase & Son

ADDRESS Broomshes

N. B.—WRITE PLAINLY, carefully supplied. AGE mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that i TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82878

CERTIFICATE OF DEATH.

24-001 D 82878

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Pamish ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Bell

(a) RESIDENCE No. 824 N. Pamish ST., WARD

(Usual place of abode) about 5

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of Charles Bell (deceased)

6 DATE OF BIRTH (month, day, and year) —— 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer Mrs. D. Smith

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Mary Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co. Md.

14 Informant Mary Bell

(Address) 829 N. Pamish

15 JAN 2 0 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 11 1924, to Jan 18 1924, that I last saw her alive on Jan 18 1924, and that death occurred, on the date stated above, at 12-50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. C. Mc Courtney, M. D.

1-18-1924 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 20 1924

20 UNDERTAKER Sam'l N. Chase Son

ADDRESS 1400 Mosher

NOTE—WRITE LEGIBLY. Spelling of Proper Names and Technical Words should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82879

D 82879

CERTIFICATE OF DEATH.

Registered No. 112

1-PLACE OF DEATH

City of BALTIMORE: (No. 3714 Falls Road St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Roy M. Shamer

(a) Residence No. 3714 Falls Road St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. Shamer

6-DATE OF BIRTH (month, day and year) Jan. 21-1895

7-AGE, 28 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Motorman 078

(b) General nature of industry, business, or establishment in which employed (or employer). U. R. & Elec. Co.

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. John T. Shamer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll Co. Maryland

12-MAIDEN NAME OF MOTHER. Maggie E. Dye

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Fredericksburg Virginia

14- (Informant) Mrs Martha E. Shamer

(Address) 3714 Falls Road

JAN 20 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 17-1924

17- I HEREBY CERTIFY, That I attended deceased from 1-14, 1924, to 1-17, 1924

that I last saw him alive on 1-17, 1924

and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Haemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Vomiting

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) E. Lee Flanagan M. D.

1-18. 1924 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Mary's (Hamden) DATE OF BURIAL. Jan. 21, 1924

20-UNDERTAKER. Horace H. Burgee ADDRESS 3631 Falls Rd.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 32880

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

× 90 D 32880

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Gilmore ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Liza Baily

(a) RESIDENCE No. 1103 Gilmore ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Baily

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middle Sex Co Virginia.

PARENTS

10 NAME OF FATHER Philip Fields

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country) Middle Sex

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant [illegible]

(Address) [illegible]

15 JAN 20 1924 ROBERT F. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-15-, 1924, to 1-18, 1924.

that I last saw h[illegible] alive on 1-18, 1924,

and that death occurred, on the date stated above, at 10:5 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism & nephritis

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank S Saunders M. D.

, 19 (Address) 123 Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middlesex Co Va	Jan 22 1924
20 UNDERTAKER	ADDRESS
Conner & Wright	1360 Cary

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 82868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82881

CERTIFICATE OF DEATH.

X 15-001 ✓

D 82881

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary, E 6 WARD)

2-FULL NAME Frank Berry

(a) RESIDENCE NO. Jonesboro, Tenn, Rt. St #2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1898

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer, 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jonesboro, Tenn.

PARENTS

10 NAME OF FATHER Robert Berry.

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ellen Rowe

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Mae. Berry
(Address) Jonesboro, Tenn.

15 FILED JAN 2 0 1924 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1924, to Jan. 19, 1924, that I last saw him alive on Jan. 19, 1924, and that death occurred, on the date stated above, at 5 05 P. m.

The CAUSE OF DEATH* was as follows:

Carbuncle; Septicemia, Hemiplegia Rt; Pneumonia.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
Pneumonia (duration) yrs. mos. 18 hrs

18 Where was disease contracted if not at place of death? Tenn. Jonesboro

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. M. Poland, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tenn. Jonesboro

DATE OF BURIAL 1/19 1924

UNDERTAKER E. Pate Draughon

ADDRESS 2620 St Paul St

N. B.—WRITE PLAINLY. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

A. J. Willis M. D.

Broncho

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82882

CERTIFICATE OF DEATH.

D 82882

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 E.Glenmore Ave ST., 27 WARD)

2-FULL NAME Chas. C. Simonini

(a) RESIDENCE NO. 12 E.Glenmore Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth (Boller)

6 DATE OF BIRTH (month, day, and year) March 11/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Hotel
(b) General nature of industry, business, or establishment in which employed (or employer) Keeper
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Caeser Simomini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Margaret Dante

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. Rinaldo Simonini
(Address) 12 E. Glenmore Ave

JAN 20 1924 Registrar

Special Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. K. Bowers, M. D.
(Coroner.)

Jan 19/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 1/21/1924

20 UNDERTAKER A. Klemann — ADDRESS 324 Broad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 82883

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 D 82883

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 McElderry ST., 7 WARD)

2-FULL NAME Frank C. Palcher (Palca)
2404 McElderry

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary (Puscar) Palcher

6 DATE OF BIRTH (month, day, and year) July 22 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor 080
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria-Hungary

PARENTS

10 NAME OF FATHER Emerick Palca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria-Hungary

12 MAIDEN NAME OF MOTHER Mary --------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria- Hungary

14 Informant Mary A Palcher
(Address) 2404 McElderry St

15 JAN2 01924 ROBERT E. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemmorhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Collins, M. D.
(Coroner.)

Jan 18/24 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 21 1924

20 UNDERTAKER Frank Crockley — ADDRESS 1906 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D 82884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 82884

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 Maple Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pereza Runge

(Residence in Baltimore: No. 214 Maple Ave St.; 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Wht

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Widow

6-DATE OF BIRTH, ... Not Known ..... 1 .....
(Month) (Day) (Year)

7-AGE, 89 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... No

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Kucera

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Rob

(Address) 214 Maple Ave

15- JAN 20 1924 ROBERT E. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 18, 1924
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 1923, to January 1924, that I saw her alive on 16th January 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

..... Chronic Interstitial Nephritis
..... Failing compensation
of heart (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Albert J Webster M. D.

Jan 19, 1924 (Address) 703 Belair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan 21, 1924

20-UNDERTAKER Paul Eccleston — ADDRESS 1906 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82885

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 N. Charles ST. W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Hupfeman

(a) RESIDENCE No. 2603-N-Charles ST. 12 WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? 81 yrs. 2 mos. 11 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nicholas A. Hupfeman

6 DATE OF BIRTH (month, day, and year): Nov-8-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Jas. G. Maynard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Naomi Deming

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Mr. N. M. Hupfeman (Address) 2603-N. Charles St.

15 JAN 20 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1921, to Jan 16, 1924, that I last saw her alive on Jan 16, 1924, and that death occurred, on the date stated above, at 9.35 A m.

The CAUSE OF DEATH* was as follows:

1. Lobar pneumonia

Cerebral hemorrhage

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. T. Stocking, M. D.

, 19 (Address) 5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Jan 21 1924

20 UNDERTAKER: Stewart & Company — ADDRESS: 104 W. North Ave.

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—I-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82886

CERTIFICATE OF DEATH.

11-001 D 82886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 Beechdale Road ST., 27 WARD)

2-FULL NAME Louis Murray Rawlins

(a) RESIDENCE No. 10 Beechdale Road ST., 27 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 59 yrs. 3 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza H.W.Rawlins

6 DATE OF BIRTH (month, day, and year) Sept-30-1864

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	59	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. of Mails at

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Md.

(c) Name of employer U.S. Government

9 BIRTHPLACE (city or town) Berry Hill
(State or country) Virginia

PARENTS

10 NAME OF FATHER Edw.A.Rawlins

11 BIRTHPLACE OF FATHER (city or town) Pohatan Co.
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Gay B.Murray

13 BIRTHPLACE OF MOTHER (city or town) Norfolk
(State or country) Virginia

14 Informant Mrs. Eliza H.W. Rawlins (wife)
(Address) 10 Beechdale Road

15 FILED JAN 2 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 - 1924 to Jan 18 1924

that I last saw him alive on Jan 18 1924

and that death occurred, on the date stated above, at 12:40 P m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchitis - Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert Tunstall, M. D.

Jan 19, 1924 (Address) 2117 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Jan-21-24
20 UNDERTAKER STEWART & BOWEN COMPANY (WILLIAM F. STEWART, Successor)	ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC... mation should be carefully supplied. AGE sho... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See Instructions on ba... E should be stated EXACTLY. It may be properly classified. Ex... ment of C... on back of certificates.

Spec- 12-23-21 - E.B.R.S.—400 Bks.

D 82887

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 82887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1017 Edmondson Ave. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Augusta Knorr

(a) Residence No. 1017 Edmondson Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles J. Knorr

6-DATE OF BIRTH (month, day and year) Feb. 10, 1856

7-AGE. 67 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William S. Stuart

11-BIRTHPLACE OF FATHER (city or town) (State or Country) New York.

12-MAIDEN NAME OF MOTHER. Clara Shetler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Miss Helen M. Knorr

(Address) 1017 Edmondson Ave.

15- JAN 2 0 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1924 to Jan 18 1924 that I last saw h.. alive on Jan 17 1924 and that death occurred, on the date stated above, at 9.25 m.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) W. G. Yeats M. D

. 19 (Address) 1055 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Jan. 21, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 Calvert St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82888 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ 31 D 82888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 828 S. Ellwood ave ~~ST.~~, 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Kenney

(a) RESIDENCE NO. 828 S. Ellwood ave ST., 1 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Patrick Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia Malone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Anne Kenney

(Address) 828 S. Ellwood ave

15 JAN 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Jan 18, 1924

that I last saw h[illegible] alive on Jan. 17, 1924

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) m McAvoy, M. D.

1/19, 1924 (Address) 829 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 1/21 1924

20 UNDERTAKER: J. G. Moran — ADDRESS 328 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 82889

HEALTH DEPARTMENT—CITY OF BALTIMORE

1924 D 82889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. ~~WARD~~)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Thomas.

(a) RESIDENCE NO 1711 William St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 55 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Yellow.	Widower.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Louise L. Thomas.

6 DATE OF BIRTH (month, day, and year) January 3, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	0	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mariner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Japan.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant John F. Thomas. (son)
(Address) 205 E. Heath St.

15 JAN 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January, 18, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental fall overboard from a boat. Exposure & shock.

12 hours.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jany. 18, 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Accident in Spring Gardens. 1/17/1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenhill — DATE OF BURIAL 1/21 1924

20 UNDERTAKER J. J. Tully & Sons — ADDRESS 618 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 82890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 99-001 D 82890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 W. West St., 7th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marie Hughes

(a) RESIDENCE NO. 521 W. West St., WARD Ac. Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (Always) 8 months 27 days. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	1	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child (Md)

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Allen Summit Md

PARENTS

10 NAME OF FATHER: Joseph Y. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lottie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Joseph Y. Hughes
(Address) 521 W. West St

15 Filed JAN 2 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from January 11, 1924, to January 20, 1924, that I last saw her alive on January 19, 1924 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) ....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Howles, M. D.

1/29, 1924 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL 1-21-24

20 UNDERTAKER: Jno D Easton

ADDRESS 916 Pa ave

N. B.—WRITE LEGIBLY. ONE SPACE FOR EACH LETTER. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82891

90

D 82891

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1820 Dover ST., 19 WARD)

2-FULL NAME John Denhardt

(a) RESIDENCE NO. 1820 Dover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 13

(b) General nature of industry, business, or establishment in which employed (or employer) in Slaughterhouse

(c) Name of employer Wm Manger Balto. Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Caspar Denhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Balto Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth Stahlman

(Address) 1820 Dover St.

15 JAN 2 0 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1923, to Jan 19, 1924, that I last saw him alive on Jan 18, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Mitral & aortic valves

about 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Kumpf, M. D.

1/19, 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Jan 21 1924

20 UNDERTAKER Wm Pickus & Sons ADDRESS North St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE mation should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82892

CERTIFICATE OF DEATH.

57 D 82892

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1620 Edmondson Ave. WARD 16)

2-FULL NAME James A. DePuey

(a) RESIDENCE NO. 1620 Edmondson Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma L. DePuey

6 DATE OF BIRTH (month, day, and year) Feb. 13, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Balto. Fire Dept

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 032

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Augustus DePuey

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Catherine Abourd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant (Address) Mrs. Emma L. DePuey 620 Edmondson Ave

15 JAN 2 0 1924 HUBERT H. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Jan 18, 1924, that I last saw h'm alive on Jan 18, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy —

(duration) ... yrs. 1 mos 20 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 6 or 7 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Benman Hood, M. D.

1/9. 1924 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL Jan 21 1924

20 UNDERTAKER Wm Fickenscher — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH CARBON PAPER. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82893

CERTIFICATE OF DEATH.

24 129 D 82893

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 429 E. Gitting st. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David O. Ryder

(a) Residence No. 429 E. Gitting St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr. 29 1876

7-AGE.	If LESS than 1 day.
47 yrs. 8 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer 63

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, David J. Ryder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Mary A. Hunt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. Y.

14-

(Informant) Mr. George Ryder

(Address) 429 E. Gitting St.

15-Registered JAN 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/19/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 ..... 19 24 to Jan 19 ..... 19 24

that I last saw h[illegible] alive on Jan 19 ..... 19 24

and that death occurred, on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Bamberger M. D

1/21 1924 (Address) 1749 Mulberry St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	1/22 19 24
20-UNDERTAKER.	ADDRESS
L. Frew McCully	130 E. Fort.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

24 D 82894

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 803 S Broadway St., 2nd WARD)

2-FULL NAME Charles F Schaible

(Residence in Baltimore: No. 803 S Broadway St. / Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... Unknown, 18.52
(Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Barber

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss. Elizabeth Amend

(Address) 206 N Linwood

15- JAN 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 18, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Jan 20, 1924 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
St Mathias Cem	Jan 23, 1924
20-UNDERTAKER	ADDRESS
Peter Nicolaus 2060	Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82895

D 82895

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Clarissa Schuette

(Residence in Baltimore: No. Dispatch St and Ashland Ave St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... November ..... 19 ....., 1843
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
80 yrs. 1 mos. 30 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country), Rochester N. Y.

PARENTS.

10-NAME OF FATHER, Joseph Schuette

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Hettinger

13-BIRTHPLACE OF MOTHER (State or Country), Alsace Lorraine

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sr. Mary Dismas

(Address) Dispatch Street

15-

Filed ..... JAN 21 1924 ....., 191.....

ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January ..... 18 ....., 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 1913 ....., to ..... Nov 19 ..... 1924 ,
that I saw her alive on ..... Nov 18 ..... 1924 ,
and that death occurred, on the date stated above, at 9.25 p m.

The CAUSE OF DEATH* was as follows:

..... Myocarditis .....
..... Acute Dilatation .....
.....

..... (Duration) ..1.... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
1130 ....., 192.. (Address) 110 E. Northern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md	Jan. 22, 1924
20-UNDERTAKER	ADDRESS
Frank A. Tisch	1161 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

82896

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 41 D 82896

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital for the Women of Maryland — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Isabella Merryman

(a) RESIDENCE NO. Grove Farm System Spring Valley ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 9 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced (or) WIFE of: James Mck. Merryman

6 DATE OF BIRTH (month, day, and year): June 1, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	0	19	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore County

12 MAIDEN NAME OF MOTHER: Frances Winchester

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore City - Md.

14 Informant: George Brown, Jr.
(Address): Washington apts. Hall. Md.

15 JAN 21 1924 ROBERT R. KRAUSER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1924, to Jan. 20, 1924, that I last saw her alive on Jan 20, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Septicemia (Streptococcus Hemolyticus)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? YES Date of Jan 10, 1924

Was there an autopsy? No — Primum — Tearing of Uter.

What test confirmed diagnosis? Blood cultures.

(Signed) G. F. Goff M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sherwood Cem. Cockeysville — DATE OF BURIAL: 1-21 1924

20 UNDERTAKER: Henry W. Jenkins & Sons Co — ADDRESS: Orchard & McCulloh Sts

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.–1-10-21 M&T 1500 Bks.

D82897

HEALTH DEPARTMENT—CITY OF BALTIMORE

D82897

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

2-FULL NAME Doris Daly

(a) RESIDENCE No. 2309 Greenmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 3 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
			1/6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Bannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Received JAN 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Jan 19, 1924, that I last saw her alive on Jan 19, 1924, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary) X (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? X

(Signed) H. H. Veech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Jan 21 1924

20 UNDERTAKER K. C. Wiedefeld — ADDRESS 914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Berman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82898 — 129 — D 82898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3717 Fremont Ave St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Berman

(a) RESIDENCE. No. 3717 Fremont Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jacob Berman

(Address) 3717 Fremont Ave

15 Filed JAN 21 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Jan 20, 1924, that I last saw h er alive on Jan 20, 1924, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) Yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) Yrs. mos. Indef ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Buchsbaum M. D.

Jan 22, 1924 (Address) 1112 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Henry Run	1/21 1924
20 UNDERTAKER: A. Lissner & Bro	ADDRESS 112 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

82899

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 D 82899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3010 E. Monument St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis F. Pinkus

(a) Residence No. 3010 E. Monument St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 30/08

7-AGE. 15 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. James Pinkus

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Louise Lupinek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant) Louisa Pinkus

(Address) 3010 E. Monument

15-

Filed JAN 2 1 1924 192.. ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 18/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 19 24 to Jan 18 19 24

that I last saw h.. alive on Jan 17 19 24

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

acute Tonsilitis

acute Spinatic arthritis

acute Endocarditis

(Duration) 1 yrs. 11/2 mos. ds.

CONTRIBUTORY (Secondary) acute dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) 24 Fred Rupp M. D

19 (Address) 20 N. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Hill

DATE OF BURIAL. 1/21 19 24

20-UNDERTAKER. Philip Herwig

ADDRESS 2016 Orleans St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should RATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82900

CERTIFICATE OF DEATH.

1-001

18 D 82900

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Jefferson ST., 6 WARD)

2-FULL NAME James. W. Crismer

(a) RESIDENCE No. 2013 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Crismer

6 DATE OF BIRTH (month, day, and year) July 10-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lather
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Geo E. Crismen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Blanch Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Adelaide Crismer
(Address) 2013 Jefferson St

15 JAN 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental
Gas Poison
(Duration) Asphyxia yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo Edw Blades, M. D.
(Coroner)

Jan 24, 1924 (Address) 1431 W Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Jan 27 1924

20 UNDERTAKER Geo M. Frit & Son

ADDRESS 811 W Fay

D 82901 HEALTH DEPARTMENT—CITY OF BALTIMORE 1924 D 82901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 649 W Lanvale St., 28 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Henry L Jacobi

(Residence in Baltimore: No. Frederick ave North End St., ...yrs. ...mos. ...ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. July 12 1896 (Month) (Day) (Year)

7-AGE. 27 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Basket Maker
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE, (State or Country). USA

PARENTS.

10-NAME OF FATHER. John Jacobi

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dorothea Krow

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Knell

(Address) 917 Columbia Ave.

JAN 21 1924 Filed ROBERT A. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 19 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ...(Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound in chest from

a Gun Suicide

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (Homicide)

(Duration) ...yrs. ...mos. ...ds.

(Signed) H. R. Fox M. D. (Coroner.)

1 20 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Mt Olivet Cem Jan 22nd 1924

20-UNDERTAKER. ADDRESS
Knell & Son 1729 W Pratt St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82902

CERTIFICATE OF DEATH.

1924 D 82902

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. German Aged Home ST.: Balto and Lyson Sts WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Lockel

(a) RESIDENCE. NO. German Aged Home ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rhanna Lockel

6 DATE OF BIRTH (month, day, and year) Nov. 11 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER George Lockel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie E. Laab.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Employee Home Records (Address) Balto and Lyson Sts

15 Undertaker ROBERT F. KRAUTER, Registrar

JAN 2 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 2nd 19... to Jan 19 1924., that I last saw him alive on Jan 18th 19..., and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John D Huff, M. D.

19 (Address) 1843 W Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 21 1924
20 UNDERTAKER Jacob L. Cook	ADDRESS 1003 W Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 ✓

D 82903

D 82903

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 E. Baltimore St., 6 WARD)

2-FULL NAME Catherine Agnes Smith

(a) RESIDENCE NO. 1700 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Charles Smith

6 DATE OF BIRTH (month, day, and year) Sept. 18 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Edward Dowling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Johnstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Nellie F. Pickett

(Address) 1700 E. Baltimore St

15 Filed ..... 19 ..... ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1924, to Jan. 20, 1924, that I last saw h[illegible] alive on Jan. 20, 1924, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Hepatic)

about (duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Morris Abramowitz M. D.

1-29-24 (Address) 1705 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Co

DATE OF BURIAL Jan 22 1924

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Balto St

IMPORTANT—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Rabe.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82904

D 82904

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. A Rabe

(a) Residence No. 1510 N. Regester St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Pauline M. Rabe

6-DATE OF BIRTH (month, day and year) Jan 30-1880

7-AGE. 43 yrs. 11 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pressman

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Decorating

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Antone Rabe

11-BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Agnes Rabe

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or Country),

14- (Informant) Municipal Hospital Records

(Address).....

15-

Filed JAN 21 1924 ROBERT N. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-19-24

17- I HEREBY CERTIFY, That I attended deceased from 1-19 19 24, to 1-19 19 24

that I last saw him alive on 1-19 19 24

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic Aortitis

Aneurysm of Aorta

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Wray M. D

1-19. 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery | DATE OF BURIAL, 1/22 19 24

20-UNDERTAKER. Chas. E. Evans & Son | ADDRESS 1811 W. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82905

CERTIFICATE OF DEATH.

45

D 82905

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Riviera Apts St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Fannie Kalm Strouse

(a) Residence No... Lake Drive & Linden Ave St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Strouse

6-DATE OF BIRTH (month, day and year) Feby 8th 1854

7-AGE, 69 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Evansville Ind

PARENTS

10-NAME OF FATHER, Solomon Kalm

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Clara Gumbus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant)..... Mr. Strouse

(Address)..... Riviera Apts

15-Filed JAN 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jany 20th 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1923 to Jany 20th 1924 that I last saw h. alive on Jany 19th 1924 and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon (Sigmoid)

Dysuptoea (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis (Perforation of Carcinoma) (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical: Symptoms & signs (mass, character of stools in

(Signed) Louis P. Hamburger M. D

Jany 21, 1924 (Address) 1707 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Chev Shalom — DATE OF BURIAL. Jany 22d 1924

20-UNDERTAKER. Hurd Sondheim — ADDRESS 1181 N. Mt Royal Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82906

CERTIFICATE OF DEATH.

D 82906

1-PLACE OF DEATH

City of BALTIMORE: (No. 1736 Ruxton Ave | 5 | Ward)

Registered No. 1-201

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Wolfram

(a) Residence No. 1736 Ruxton Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

Single, Married, Widowed or Divorced: (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Rose Wolfram

6-DATE OF BIRTH (month, day and year): Jany 13 1849

7-AGE: 75 yrs. — mos. 8 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Dry Goods

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Benj. Wolfram

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11- (Informant): Mrs. E. Wolfram

(Address): 1736 Ruxton Ave

15- Filed JAN 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/20/24

17- I HEREBY CERTIFY, That I attended deceased from January 13 1924 to January 20 1924

that I last saw him alive on January 19 1924,

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Cardiac Decompensation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. O. Bellman M. D

, 19 (Address) Towson, Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew

DATE OF BURIAL: 1/22/, 1924

20-UNDERTAKER: David Sondheim

ADDRESS: 1810 W. Mt. Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-24—M&T—1500 Blks.

82907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1713 E. Oliver (St.) (8) (Ward)

2-FULL NAME George E. Heyl

(a) RESIDENCE (Usual place of abode) No. 1713 E. Oliver St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Anna D. Heyl

6 DATE OF BIRTH (month, day, and year) Sept. 13 1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto. Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George Heyl

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Margaret Lochmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna D. Heyl

(Address) 1713 E. Oliver St.

15 Filed JAN 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 18, 1924,

that I last saw him alive on Jan 18, 1924,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O O Lloyd, M.D.

19 (Address) 1713 E Oliver St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 22 1924

20 UNDERTAKER Henry Hoeck Sons ADDRESS 1501 E Eager St

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82908 82908

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hospital ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Augustine Dooper

(a) RESIDENCE NO. St James Rectory E. Eager st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergy 065

(b) General nature of industry, business, or establishment in which employed (or employer) Catholic Priest.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Rev Rector Mountcastle

(Address) St James Church 1205 Eager st

15 JAN 2 1 1924 HUBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 23. 1924, to Jan. 19 1924, that I last saw h. alive on Jan. 19 1924, and that death occurred, on the date stated above, at 7 32 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Subacute Bronchitis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec 24 '23.

Was there an autopsy? No.

What test confirmed diagnosis? ? S.S. & Operation findings

(Signed) Harold C. Gilchrist, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 23 1924
20 UNDERTAKER	ADDRESS
Henry Lorch Sons	1301 E Eager st

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82909 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4/6 82909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 Winchester ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia. M. Tabeling

(a) RESIDENCE NO. 2803 Winchester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced (or) WIFE of Anthony J. Tabeling.

6 DATE OF BIRTH (month, day, and year) 2nd Nov

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	abt. 58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER James F. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Molloy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant Mr. Stanley Maxwell

(Address) 2803 Winchester st

15 JAN 21 1924 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from August, 1923, to Jan. 20, 1924, that I last saw her alive on June 19, 1923, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

August 1923 to Jan 1924 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gout Knee (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? NS

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) H K Jamison M. D.

Jan 24 19 (Address) 117 N Bond st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan. 23 1924

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager st

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S·A·E

D A K

D 82910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

167 D 82910

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 322 N. Paca St. 4 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. J. Lynch

(Residence in Baltimore: No. 322 N. Paca St St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: June 16 1869
(Month) (Day) (Year)

7-AGE: 54 yrs. 7 mos. 2 ds. If LESS than 1 day, ... hrs. or .... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mrs. Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: M. A. Lynch

11-BIRTHPLACE OF FATHER. (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Rosa M. Sellers

13-BIRTHPLACE OF MOTHER. (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Lynch

(Address) 5106 Grove ave

15-

Filed ..... 192.. ROBERT N. KRAUTER, Registrar.

JAN 2 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Stenosis Tox

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

1-20 192.. (Address) .....

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Carmel — DATE OF BURIAL, Jan 21 1924

20-UNDERTAKER: Burkler & Burkler — ADDRESS 1739 Eager st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82911 — 113 — D 82911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 S. East Ave ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lubinski Jr

(a) RESIDENCE No. 1103 S. East Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred, Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 26. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William Lubinski Sr

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Malczewski

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant William Lubinski Sr (Address) 1103 S. East Ave

15 JAN 2 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1924 to Jan. 19, 1924 that I last saw h.. alive on Jan. 19, 1924 and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L B Bromwhas, M. D.

1-20 1924 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Jan 21 1924
20 UNDERTAKER	ADDRESS
Stephen J Fiskowski	1005 S Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Frances M Early.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82912

CERTIFICATE OF DEATH.

129 D 82912

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 W. Charles St. ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Moale Early.

(a) RESIDENCE NO. 1800 W. Charles St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) ~~WIFE~~ of Alexander P. Early.

6 DATE OF BIRTH (month, day, and year) Nov 30th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Henry Moale.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margaretta Elderdice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Francis I. M. Early 1800 W. Charles St.

15 JAN 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20 1924

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1924, to January 20, 1924, that I last saw her alive on January 19, 1924, and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 years mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

(Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary Cem	Jan 22 1924
20 UNDERTAKER	ADDRESS
Harry W. Jenkins Sons Co	McCulloh & Orchard

NOTE—WRITE LEGIBLY with unfading ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Gordon M. Bushong

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82913

CERTIFICATE OF DEATH.

100-001 D 82913

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 St Charles ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon M. Bushong.

(a) RESIDENCE. NO. 309 Cedar ST., Wilkens WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 29th 1923

7 AGE — Years: — Months: 7 Days: 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Earl M. Bushong

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga.

12 MAIDEN NAME OF MOTHER: Edna K. Schweitzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Earl M. Bushong

(Address) 1724 St Charles st

15 Filed ... 19 ... Registrar

JAN 21 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 17. 1924. (to) Jan 20. 1924.

that I last saw him alive on Jan 19. 1924.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert Faser, M. D.

1924 (Address) 1 E Randall Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Jan 22 1924

20 UNDERTAKER: E. Schloman & Son — ADDRESS: 1039 Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82914

100 1001 D 82914

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N Carey ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Johns

(Residence in Baltimore: No. 709 N Carey St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, August 16, 1922 (Month) (Day) (Year)

7-AGE, 1 yrs. 5 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.†

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harrie Johns

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Anderson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Anderson

(Address) 709 N Carey St

15- FILED JAN 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 19, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1923, to Jan 19 1924, that I saw him alive on Jan 18 1924, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Rachitis

(Duration) yrs. 4 mos. ....ds.

(Signed) H. S. McCard M. D.

1/20, 1924. (Address) 1005 Dolfield Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Jan 21, 1924.

20-UNDERTAKER John H Tordrin — ADDRESS 1027 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 82915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/28 D 82915

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Park Avenue St., 11 WARD)

2-FULL NAME Robert Brown

(a) RESIDENCE NO. 1121 Park Avenue St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anne Brown

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gordon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dent Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anne Brown

(Address) 1121 Park ave

15 Filed JAN 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 31st, 1923, to Jan 18th, 1924, that I last saw him alive on Jan 16th, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 19 ds.

CONTRIBUTORY (Secondary) Exhaustion Old

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

1/18, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery — DATE OF BURIAL Jan 21 1924

20 UNDERTAKER John H Owens — ADDRESS 338 Dolphin

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1800 Blks.

D 82916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 ✓ D 82916

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St Agnes Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Martini

(a) RESIDENCE No. 1271 Pargent St. City St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Walter Martini

(Address): 1271 Pargent St City

15 JAN 2 1 1924 ROBERT R. KRAUSER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1924, to Jan. 17, 1924, that I last saw him alive on Jan. 17, 1924, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Peri-Rectal Abscess

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-12-23.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Stanger, M. D.

, 19 (Address) Church Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: Jan 24 1924

20 UNDERTAKER: J. Wm Fields

ADDRESS: 1200 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Bks.

68 826 D 82917

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-003 D 82917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Baby Owings

(a) RESIDENCE NO. 917 W. Fayette ST., [illegible] WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Owings

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Hazel Leland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) .....

15 JAN 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Jan 11, 1924, that I last saw h[illegible] alive on Jan 11, 1924, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) ..... yrs. ..... mos ? ds.

CONTRIBUTORY (Secondary) Spina Bifida

(duration) ..... yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A Blalock, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

Commissioner Health.

JAN 21 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82918

CERTIFICATE OF DEATH.

31 D 82918

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 N. Eden St. ST., 10 WARD)

2-FULL NAME William Conrad

(a) RESIDENCE NO. 1002 N. Eden St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 7, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lock Smith 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER Frederich Conrad

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Friedericke Dietrich

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant George Conrad,
(Address) 1002 N. Eden St.

15 FILED JAN 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 19. 1924

17 I HEREBY CERTIFY, That I attended deceased from January 1 19 24 to January 19 24

that I last saw him alive on January 19 24

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 19 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles H. A. Meyer M. D.

1/21 1924 (Address) 1032 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan. 22, 1924
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 82919

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2243 Brunt ST., 14 WARD)

2-FULL NAME Margarett A. Gladden

(a) RESIDENCE NO. 2243 Brunt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13-1923

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Arthur J. Gladden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elinor Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Arthur J. Gladden
(Address) 2248 Brunt St

15 JAN 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1924

17

I HEREBY CERTIFY, That I attended deceased from 1/18, 1924, to 1/20, 1924,

that I last saw h— alive on 1/19 —, 1924,

and that death occurred, on the date stated above, at 12:40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bruce Clutter, M. D.

1/20, 1924 (Address) 2149 Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. T. Auburn County — DATE OF BURIAL: 1-22 1924

20 UNDERTAKER: George T. V. Gibson — ADDRESS: 1735 Druid Hill

N. B.—WRITE PLAINLY with unfading ink. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 ✓

D 82920

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

2-FULL NAME James Mitchell

(a) RESIDENCE No. Stemmers Run, Balto Co WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3rd 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer) Express

(c) Name of employer Adams Express Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER James Mitchell

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline LaRue

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant John L. Mitchell
(Address) Rossville Md.

15 JAN 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21-1924

17 I HEREBY CERTIFY, That I attended deceased from 12-7-1923, to 1-21-1924, that I last saw him alive on 1-21-1924 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Cirrhosis
Chronic nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis & pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1-11-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings & History

(Signed) H. J. Cain, M. D.

1/21, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan. 23, 1924
20 UNDERTAKER	ADDRESS
Fred'k Rossetter & Sons	Fulleston

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82921

31 D 82921

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2808 Erdman Ave. ST., 8 WARD)

2-FULL NAME Francis M. Shelton

(a) RESIDENCE NO. 2808 Erdman Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie C. Shelton

6 DATE OF BIRTH (month, day, and year): Dec. 25th 1884

7 AGE — Years: 39 — Months: — — Days: 25 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture

(c) Name of employer: Meidling Bros.

9 BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: Joseph Edar Shelton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D. C.

12 MAIDEN NAME OF MOTHER: Verlinda Bagley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D. C.

14 Informant (Address): Mrs. Minnie C. Shelton 2808 Erdman Ave.

15 FILED JAN 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923 to Jan 20, 1924 that I last saw him alive on Jan 19, 1924 and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Form Leading (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. H. Cushing, M. D.

Jan 20 1924 (Address) 3100 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Congressional Cem. Washington D.C.

DATE OF BURIAL: Jan. 22, 24

UNDERTAKER: Fred Lasaster & Son

ADDRESS: Baltimore

Spec.—1-10-21—M&T—1500 Bks.

82922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 1 D 82922

1-PLACE OF DEATH The Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd. ST., (Or. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irving McRoss, Jr.

(a) RESIDENCE NO. 813 Homestead ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	0	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Irving Ross

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Young

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md
(State or country)

14 Informant Mrs. Irving Ross

(Address) 813 Homestead

JAN 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Jan. 18., 1924, to Jan. 21, 1924,

that I last saw him alive on Jan. 20, 1924,

and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Paul A. Rothpuace. M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 22nd 1924
20 UNDERTAKER	ADDRESS
Poteet & Co	1734 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 90 D 82923

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 Stark (North Cor + Eat) St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Shorter

(Residence in Baltimore: No. Towson Md St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Don't Know

6-DATE OF BIRTH: Don't Know (Month) (Day) (Year)

7-AGE: about 80 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Don't Know

PARENTS.

10-NAME OF FATHER, " " "

11-BIRTHPLACE OF FATHER, (State or Country), " " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER, (State or Country), " " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matilda Clegins

(Address) Towson Md

15. JAN 2 1 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Council M. D.
(Coroner.)

..... 192.. (Address) 121 W. Pleasant

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Towson Md

19-PLACE OF BURIAL OR REMOVAL, Loyola Cem — DATE OF BURIAL, Jan 21 1924

20-UNDERTAKER, Samuel A Hendrickson — ADDRESS 17 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82924

CERTIFICATE OF DEATH.

129 D 82924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (Sts.) 16 (WARD)

2-FULL NAME Thomas McCormack

(a) RESIDENCE No. 250 Druid Hill Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine McCormack

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel McCormack

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Winifred Dalton

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Reed
(Address)

15 Filed JAN 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/17/24, 19..., to 1/19/24, 19...,

that I last saw h... alive on 1/14/24, 19...,

and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) K. W. Foley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 1/21/1923

20 UNDERTAKER Geo. A. Finley Funeral Home

ADDRESS Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82925

CERTIFICATE OF DEATH.

B 82925

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. Fulton ave. WARD 19)

2-FULL NAME Mrs. Catherine Murphy.

(a) RESIDENCE No. 105 N. Fulton ST., WARD Baton Mass

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. 3 mos. X ds. How long in U. S., if of foreign birth? 63 yrs. ? mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Dennis F. Murphy

6 DATE OF BIRTH (month, day, and year): Mar. 13-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
67 -		10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Cheshire England.

PARENTS

10 NAME OF FATHER: Mr. Mulqueeney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland (?)

12 MAIDEN NAME OF MOTHER: Not known to informant.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant: Mrs. Margaret Cuttenden

(Address): 105 N. Fulton Ave.

15 JAN 2 1924

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from about Dec. 1st 1923 to Jan. 20th 1924,

that I last saw her alive on Jan. 20th 1924,

and that death occurred, on the date stated above, at 6.35 P. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary oedema, about 2 weeks ago, & not fully recovered yet.

(duration) yrs mos ds.

CONTRIBUTORY (Secondary): Chronic dilatation of heart.

Bright's Disease (duration) 2 yrs. or more.

18 Where was disease contracted if not at place of death? At home in Boston,

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? General symptoms. with albuminuria, etc.

(Signed) C. H. Hoffman, M. D.

1/20/1924 (Address) 3402 Wallnook ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boston Mass	1/21 1923
20 UNDERTAKER	ADDRESS
George A Fahy	Fulton & Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Lubbehusen

HEALTH DEPARTMENT—CITY OF BALTIMORE

82926

CERTIFICATE OF DEATH.

D 82926

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1038 W Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frank G Lubbehusen

(a) Residence No..... 1038 W Fayette St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Susanna Cooper.

6-DATE OF BIRTH (month, day and year) Oct 28 1861

7-AGE, 62 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Plumber

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 059

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Lubbehusen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa M Lange

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

11-(Informant) Mrs Susanna Lubbehusen

(Address) 1038 W Fayette St

15- Filed JAN 2 1 1924 ROBERT W. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 19 th 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 13 1924 to Jan 19 1924, that I last saw him alive on Jan 19 1924, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright's

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Robert Kerch M. D.

19 (Address) 305 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem | DATE OF BURIAL, Jan 5 1924

20-UNDERTAKER, Wm F Cowen & Sons | ADDRESS 901 Walker

for F Cowen & Sons

Should be clearly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82927

CERTIFICATE OF DEATH.

D 82927

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 W Baltimore St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Kate E Jubb

(a) Residence No. 1709 W Baltimore St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Jubb

6-DATE OF BIRTH (month, day and year) Feb 28 1860

7-AGE. 63 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Jacobville Md

PARENTS.

10-NAME OF FATHER, Wesley Linthicum

11-BIRTHPLACE OF FATHER (city or town) (State or Country), B A Co Maryland

12-MAIDEN NAME OF MOTHER, Margaret Leach

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) John Jubb

(Address) 1709 W Baltimore St

15- ROBERT R. KRAUTER, Registrar.

FILED JAN 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Jan 20, 1924

that I last saw h.. alive on Jan 20, 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R B L Campbell M. D.

Jan 21, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Carmel Cemetery B A Co Via Auto	Jan 23, 1924
20-UNDERTAKER. John F. Denny	ADDRESS 765 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82928

CERTIFICATE OF DEATH.

74-901 ✓ 82928

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 204 Warren Ave St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A Sessions

(a) Residence No. 204 Warren Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Sessions

6-DATE OF BIRTH (month, day and year) Oct 16 1848

7-AGE. 75 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Fish - Dealer

(b) General nature of industry, business, or establishment in which employed (or employer). 045

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Augustus D. Sessions

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Hester J. Turner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant). Edwin L. White

(Address) 836 Hillen St

15- Filed JAN 21 1924 ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 20 1924

17- I HEREBY CERTIFY, That I attended deceased from 12-20 1923 to 1-20 1924

that I last saw h[illegible] alive on 1-20 1924

and that death occurred, on the date stated above, at 2.35 p m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis, with hypertension

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James Brown M. D.

. 19 (Address) 1319 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cemetery

DATE OF BURIAL. Jan 22 1924

20-UNDERTAKER. John F Dinny

ADDRESS 715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82929

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. D 82929

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., W WARD)

2-FULL NAME Fortunate Gilly

(a) RESIDENCE No. 736½ W Saratoga St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb — 1923

7 AGE: Years X | Months // | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jeanette ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 JAN 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 - 1924, to Jan 20 - 1924, that I last saw him alive on Jan 20 - 1924, and that death occurred, on the date stated above, at 6¹⁰ a. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Bagg M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rood Cem. DATE OF BURIAL 1/21/24

20 UNDERTAKER Geo J Ruth ADDRESS 1730 Harford Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82930

CERTIFICATE OF DEATH.

91-002

D 82930

1-PLACE OF DEATH

City of BALTIMORE: (No. 2162 Boyd St., 70 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurfield Cookley

(Residence in Baltimore: No. 2162 Boyd St. St.; yrs. 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. May (Month) 2nd (Day) 1841 (Year)

7-AGE. 82 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Statistician
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer Office

9-BIRTHPLACE, (State or Country). South Carolina

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER, (State or Country) "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Cookley

(Address) 2162 Boyd St

15. JAN 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 19 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H Taylor M. D. (Coroner.)

Jan 20 1924 (Address) 711 Chase St

*State the **Disease Causing Death**, or, In deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Jan. 22 1924

20-UNDERTAKER, George L Schwab — ADDRESS, 2101 Eutaw Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 W. Fayette St., 24 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles E. Pearson

(a) Residence No. 1844 Eight St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 14-1867

7-AGE. 56 yrs. 2 mos. 6 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Grocer

(b) General nature of industry, business, or establishment in which employed (or employer). Self

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Robert Pearson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Anna M. Pearson

(Address) 915 W. Fayette St

15- 19 Registrar.

JAN 2 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 5, 19 24, to Jan 20, 19 24

that I last saw h[illegible] alive on Jan 16, 19 24

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wallace Sun, M. D.

1 7, 1924 (Address) 6 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL, Jan. 23, 1924

20-UNDERTAKER. Geo. J. Smith ADDRESS 1532 Hollins St.

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 82932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82932

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 E. Lombard St.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Apollonia Kissner

(Residence in Baltimore: No. 2020 E. Lombard St.; 65 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 7 (Day), 1841 (Year)

7-AGE, 82 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. John Schnell

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emma Wagner

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benedict Kissner

(Address) 2020 E. Lombard

15- Robert P. Harrison,

(Undertaker) ....., 191.....

Burial Permit ..... Registrar.

JAN 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day), 1924 (Year)

17- I HEREBY CERTIFY. That I attended deceased from Jan. 14, 1924, to Jan. 18, 1924, that I saw her alive on Jan. 18, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

..... (Duration) ..... yrs. ..... mos. 4 ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) Emjen L. Pearson M. D.

1-21-24, 191... (Address) Ten Hills

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan. 21, 1924

20-UNDERTAKER Wendell Dypert & Co — ADDRESS 37 Bl...

EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82933

CERTIFICATE OF DEATH.

65-

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 St Paul ST.; 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Kelly Wagner —

(a) RESIDENCE. No. 3038 St Paul ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20 - 1899

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
24	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer) Martin Wagner & Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo J. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Frances B. Kalmey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Wilmer W. Wagner

(Address) 5548 University Parkway

15 Filed JAN 21 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to Jan 20, 1924, that I last saw him alive on Jan 19, 19 24, and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia

(duration) 2+ yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood picture etc

(Signed) Wm J. Watson, M. D.

Jan 21 1924 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 27 1924

20 UNDERTAKER Geo Jacobs & Son ADDRESS 217 S. Paca st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 82934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82934

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2820 Auchentoroly Terrace St., 13 WARD)

2-FULL NAME George Heer,

(a) RESIDENCE NO. 2820 Auchentoroly Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna D. Heer,

6 DATE OF BIRTH (month, day, and year) July 25. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Heer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna K. Heer.

(Address) 2820 Auchentoroly Terrace

15 Filed JAN 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923 to Jan 20, 1924

that I last saw h[illegible]live on Jan 20, 1924

and that death occurred, on the date stated above, at 10.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia hypostatic

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Nathaniel Barb, M. D.

, 19 (Address) 2731 Parkwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Jan. 23 1924
20 UNDERTAKER Geo W Little	ADDRESS 2700 EDMONDSON AVE.

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82935

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 129

City of BALTIMORE: (No. 3322 Piedmont Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tuohy

(a) Residence No. 3322 Piedmont Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (~~Write the word.~~): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Bailon

6-DATE OF BIRTH (month, day and year): Oct 27 1838

7-AGE: 85 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engineer 030
(b) General nature of industry, business, or establishment in which employed (or employer): Smith-Dickson
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Lilburn P. Kuhn

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Rachel Mills

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-
(Informant): E. W. Mathis
(Address): 3322 Piedmont

15-
Filed ..... 192.....
Registrar.

JAN 27 1924
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 20. 24

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 19, 1924

that I last saw h.m. alive on Jan 19, 1924

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

unknown (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Wallace McCoy, M. D.

1.20. 1924 (Address) 2406 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cem Roland ave — DATE OF BURIAL: 1/22 1924

20-UNDERTAKER: Wm Cook Co — ADDRESS: 502 E Fayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82936

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2902 Garrison Blvd ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Wilson Jones

(a) RESIDENCE NO. 2902 Garrison Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 3 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58		4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New London

(State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Susan L. Dorsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll Co Md.

14 Informant Mrs. John M. Herring

(Address) 34 East 25th Street

15 JAN 21 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 20, 1924,

that I last saw h[illegible] alive on Jan 19, 1924,

and that death occurred, on the date stated above, at 3 PM 4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alonzo B Lennard, M. D.

1/21, 1924 (Address) 718 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Central M. P. Church, Cem. near New Market Md

DATE OF BURIAL Jan 22 1924

20 UNDERTAKER H. Allen Fuller

ADDRESS 2902 Garrison Blvd

INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... ns on back of certificates.

N2

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82937

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 82937

CERTIFICATE OF DEATH.

100-00 1

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Yeager

(a) Residence No. 413 S. Haderia St. St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1848

7-AGE. 74 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER (city or town): ? (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town): ? (State or Country): Unknown

14- (Informant): Municipal Hospital Record
(Address):

15- Filed JAN 21 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 9, 1924 to January 18, 1924 that I last saw him alive on January 18, 1924 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Emphysema
Chronic Bronchitis
(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho-Pneumonia
(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr.

(Signed) Claude T. Evans M. D

1-19- 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Jan 22 1924
20-UNDERTAKER.	ADDRESS
John A. Weber	1803 Bank St

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should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82938 ✓ 139 D 82938

CERTIFICATE OF DEATH

1-PLACE OF DEATH The Howard A. Kelly Hosp. REGISTERED NO.....

CITY OF BALTIMORE: (No. 1418 Eutaw Place WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Keelle

(a) RESIDENCE No. 558 - 12th St WARD .....
(Usual place of abode) Niagara Falls N.Y.
Length of residence in city or town where death occurred ___ yrs. ___ mos. 6 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. John Keelle

6 DATE OF BIRTH (month, day, and year) Dec 31, 1880

7 AGE 43 Years 0 Months 21 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Niagara Falls N.Y.

PARENTS
10 NAME OF FATHER David S. Marshall
11 BIRTHPLACE OF FATHER (city or town) Edinburgh (State or country) Scotland
12 MAIDEN NAME OF MOTHER Margaret Forgan
13 BIRTHPLACE OF MOTHER (city or town) Edinburgh (State or country) Scotland

14 Informant Mr. John Keelle
(Address) Niagara Falls New York

15 FILED JAN 2 1924 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Monday Jan 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Jan 21, 1924
that I last saw h.. alive on Jan 21, 1924,
and that death occurred, on the date stated above, at 8 40 p. m.
The CAUSE OF DEATH* was as follows:
Pelvic Abscess.
Febroid Tumor of Uterus
Secondary Anaemia
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Secondary Anaemia yrs. ..... mos. 0 0 ds.

18 Where was disease contracted if not at place of death? Niagara Falls N.Y.
Did an operation precede death? yes Date of Jan 21, 24
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) Grant Edward, M. D.
, 19 (Address) 141 E Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Niagara Falls N.Y. DATE OF BURIAL Jan 22 1924

20 UNDERTAKER Chas. G. Black ADDRESS 742 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Imperial

Spec.—1-10-21—M&T—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

82939 JOHNS HOPKINS HOSPITAL. D 82939

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Edith Greenleaf

(a) RESIDENCE No. 1430 Davison St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Greenleaf

11 BIRTHPLACE OF FATHER (city or town) Ga (State or country)

12 MAIDEN NAME OF MOTHER Hattie Reese

13 BIRTHPLACE OF MOTHER (city or town) Ga (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 2 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923, to Jan 20, 1924, that I last saw h[illegible] alive on Jan 20, 1924, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Secondary Bronchopneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Pertussis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Casper Rothstein M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL 1/22/24

20 UNDERTAKER Samuel Handley ADDRESS 1[illegible] Bank

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 82940

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3401 Clifton ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tamma Stoner Reisler

(a) Residence No. 3401 Clifton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edward Reisler

6-DATE OF BIRTH (month, day and year) Dec 23 52

7-AGE. 71 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Works

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ephram Stoner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Edward Reisler

(Address) 3401 Clifton ave

15- JAN 2 1924 ROBERT S. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 19 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1922 to Jan 20 1924

that I last saw h.. alive on Jan 19 1924

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of liver

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Nisbett M. D.

Jan 24 19 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Ridge Cem. DATE OF BURIAL, Jan 22, 1924

20-UNDERTAKER. W. M. Rondeau ADDRESS 2215 N Smith

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1900 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82941

100-002

D 82941

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1307 E. Fayette St.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Marelli Roberts

(a) RESIDENCE. No. 1307 E. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balt Md.

PARENTS

10 NAME OF FATHER John Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clara Karlsruher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Roberts
(Address) 1307 E Fayette St

15 Filed JAN 21 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1924 to Jan 20 1924,

that I last saw h[illegible] alive on Jan 19 1924,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cap. Bronchitis

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) H Lawston (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Clinical

(Signed) Geo. Couter Wades, M. D.

Jan 21 1924 (Address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Jan 22 1924
20 UNDERTAKER	ADDRESS
Joseph Ahrens	22 Avery

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

REGISTERED NO. D 82942

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Henry Moore

(a) RESIDENCE No. 1107 Melodie ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Marie moore

6 DATE OF BIRTH (month, day, and year) Sept 24 1877

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Dist Motor Service Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Forrest Maryland

PARENTS

10 NAME OF FATHER John Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs F M Lyles

(Address) 103 York Rd Towson

15 FILED JAN 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-15 , 1924, to 1-20 , 1924.

that I last saw him alive on 1-20 , 1924

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer

Acute diffuse peritonitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 1-15-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H H Kerr M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Marie Towson — DATE OF BURIAL 1/23 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Pratt

(Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Cor.—1-12-23—M&T—100 Bks.

D 82943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-000 D 82943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Leadenhall St. ST., 23 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Johnson. (C)

(a) RESIDENCE No 1016 Leadenhall St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) July, 11, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A.A.Co.Md.

PARENTS

10 NAME OF FATHER Jacob Johnson. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A.Co.Md.

12 MAIDEN NAME OF MOTHER Henrietta Landman. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A.Co.Md.

14 Informant William Pulley (C)
(Address) 1016 Leadenhall St.

15 Filed JAN 2 1924 192 ROBERT R. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) 1 yrs. ... mos. ... ds.

(Signed) Otto Reinhardt (Coroner.) M. D.

Jan, 21, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 2 1924
20 UNDERTAKER	ADDRESS
J. Lo. Brown & Son	108 N. Mon[illegible]

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-
that it may be properly classified. PHYSICIANS should state
so stated in plain terms, so that it may be stated EXACTLY.

Spec.—1-10-21—M&T—1500 Blks.

82944

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129D 82944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Burgundy ST., 72 WARD)

2-FULL NAME Rachel Brown

(a) RESIDENCE No. 636 Burgundy ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Brown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 53 — Months: - — Days: - — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Minnie Smith

(Address) 218 Dallas St.

15 JAN 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/18/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/30/ 1923 to 1/18/ 1924, that I last saw h alive on 1/18/ 1924, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Microscopical

(Signed) [illegible], M. D.

1/21/ 1924 (Address) 908 S Shp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: Jan 25 1924

20 UNDERTAKER: S N Brown & Son — ADDRESS: 108 W Monto

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Fludd)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82945

CERTIFICATE OF DEATH.

188-001

D 82945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arinthed B. Fludd

(a) RESIDENCE NO. 1128 Hanover ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Flood

6 DATE OF BIRTH (month, day, and year) Unknown Oct-6, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Crisfield Md

037

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER A. P. Webster

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Webster

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. E. Fludd.
(Address) 1128 Hanover St

15 Filed JAN 2 1924 193 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injury to Liver and other injuries. Struck by Engine

about 3 mos (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

(Signed) Clarence Peter, M. D.
(Coroner.)

Jan 24, 1924 (Address) 1128 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) At place of death 3 mos. about yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crisfield Md.	1-23 1924
20 UNDERTAKER E. B. Hall	ADDRESS 115 E. West St.

BEFORE filling out the Certificate, READ CAREFULLY. PHYSICIANS should be stated AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82946

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 22 E. Spring Ave. (St.) Raspeburg (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia L. Giese

(a) RESIDENCE No. 22 E. Spring Ave. ST. Raspeburg WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	41	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Trained Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer): 048

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William F. Giese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise A. Bayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) William F. Giese 22 E. Spring Ave Raspeburg

15 Filed JAN 2 1924 Registrar

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923 to Jan 21 1924, that I last saw h alive on Jan 21, 1924, and that death occurred, on the date stated above, at 12 00a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

Jan 21, 1924 (Address) Raspeburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan 23, 1924
20 UNDERTAKER	ADDRESS
Fredk Leas Sons & Sons	Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82947

CERTIFICATE OF DEATH.

90 D 82947

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 744 Dolphin St., 17 Ward)

2-FULL NAME Charlotte White

(a) RESIDENCE No. 744 Dolphin St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry White

6 DATE OF BIRTH (month, day, and year) Dec 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
55	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Edw Dutton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Coutee

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mary White
(Address) 744 Dolphin St

15 JAN 21 1924 ROBERT R. KRAUTER, Secretary
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. —, 1924, to Jan 20th, 1924

that I last saw h[illegible] alive on Jan. 19th, 1924

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Organic Heart dis.
Uremia

(duration) yrs. 6 mos 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. [illegible], M. D.

1924 (Address) 924 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem

DATE OF BURIAL Jan 24 1924

20 UNDERTAKER John H Owens

ADDRESS 538 Dolphin St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82948 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 3/D 82948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Flossie Breeden

(a) RESIDENCE No. 1431 Orleans st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Tate Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jemima Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) M.C.H. [illegible] KRAUTER

15 JAN 2 1924

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to Jan. 20, 1924, that I last saw her alive on Jan. 20, 1924, and that death occurred, on the date stated above, at 4.25 a.m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lallier, M. D.

1-20, 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Jan 22 24

20 UNDERTAKER Mrs R A Elliot ADDRESS 725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 82949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 82949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. Collington Ave ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANGELIA MANTIK,

(a) RESIDENCE NO. 215 S.Cllington Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. I mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 23-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	I	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER William Mantik,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Szafranski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Mary Mantik,
(Address) 215 S.Collington Ave.

15 Filed JAN 21 1924 ROBERT R. ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1924

17 I HEREBY CERTIFY, That I attended deceased from January 18. 1924. to January 21. 1924.

that I last saw her alive on January 20. 1924

and that death occurred, on the date stated above, at 5. A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar M. Otley M. D.

July 24 1924 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Jan. 22, 1924.

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann.

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82950

Registered No. D 82950

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 E. 22nd St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rachel R. Forrester

(a) Residence No. 417 E. 22nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

3a-If married, ~~widowed~~, or ~~divorced~~, HUSBAND of (or) WIFE of Washington Forrester

6-DATE OF BIRTH (month, day and year) Jan 14, 1863

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Lemuel Plumpton

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Mary Hammond

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14-INFORMANT: Washington Forrester

ADDRESS: 417 E. 22nd

JAN 22 1924

Filed ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 21st '24

17- I HEREBY CERTIFY, That I attended deceased from Jan 22nd 1923 to Jan 22nd 1924 that I last saw h. alive on Jan 21st 1924 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) 0 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of 0

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings.

(Signed) August Kohn M. D

. 19 (Address) 4 E 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 24 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 501 E Monument

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

16878

D 82951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001

D 82951

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Walker

(a) RESIDENCE NO. 1029 No Bulbuyk St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE — Years: 23 — Months: ? — Days: ? — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mildred Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

JAN 2 2 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1924, to Jan 19, 1924.

that I last saw her alive on Jan 19, 1924.

and that death occurred, on the date stated above, at 2-12 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Possibly Typhoid fever (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home 1200 Argyle Ave

Did an operation precede death? Yes. Date of ① Dec 30, 1923 ② Jan. 14, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) W. W. Peiniele M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Staunton Va

DATE OF BURIAL: Jan 22 1924

20 UNDERTAKER: Jas. H. Dennis

ADDRESS 1305 Preston

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82952

CERTIFICATE OF DEATH.

13 D 82952

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Fawn ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelo Prussotti

(a) RESIDENCE. No. 1014 Fawn ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	✓	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Carmelo Prussotti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Ballee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Carmelo Prussotti
(Address) 1014 Fawn

15 JAN 2 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 16 1924 to Jan 20 1924

that I last saw h alive on Jan 20 1924

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cervical Adenitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? nr Date of —

Was there an autopsy? nr

What test confirmed diagnosis?

(Signed) Emily F Cataliato M. D.

1-21 1924 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 22 1924
20 UNDERTAKER	ADDRESS
Windell Dippel & Son	378 Mn

NOTICE TO PHYSICIANS AND UNDERTAKERS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Orange Robinson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82953

CERTIFICATE OF DEATH.

101-801 D 82953

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 74 Redwood ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orange Robinson

(a) RESIDENCE. NO. 74 Redwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hanna Robinson

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Alex Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura Robinson

(Address) 74 Redwood St

15 JAN 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1924, to Jan 20, 1924, that I last saw him alive on Jan 20, 1924, and that death occurred, on the date stated above, at 10 40 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

Jan 22, 1924 (Address) 126 Ausquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Augusta Ga	Jan 23 1924

20 UNDERTAKER ADDRESS

R C Gross 1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 82954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82954

CERTIFICATE OF DEATH.

X 179

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Dixon

(a) Residence No. 218 W. Biddle St. St., Ward Raleigh N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colrd

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, (HUSBAND) of (or) WIFE of Alfred H. Dixon

6-DATE OF BIRTH (month, day and year) Jan 16 05

7-AGE. 19 yrs. mos. 3 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wrk

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER. Sarah Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N. C.

11- (Informant) Alexandra Johnson

(Address) 537 N. Mount St

15- Filed JAN 22 1924 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 19-24

17- I HEREBY CERTIFY, That I attended deceased from January 19 1924 to January 19 1924 that I last saw her alive on January 19 1924 and that death occurred, on the date stated above, at 7-35 P. m. The CAUSE OF DEATH* was as follows:

Secondary Disease Burns of entire body (scalp, scalp and upper part of face.) Accidental.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis?

(Signed) Wm. J. Fulton M. D

1-20 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Raleigh, N. C. DATE OF BURIAL. Jan 22nd 1924

20-UNDERTAKER. Sam'l W. Chase Est ADDRESS 1400 Madison St

CORONER FOR BALTIMORE CITY-EASTERN DISTRICT

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Lighting a gas stove.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 82955 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 82955

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1132 W Cross St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E H Rauman

(a) Residence No. 1132 W Cross St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married or Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) J C Rauman

6-DATE OF BIRTH (month, day and year) Oct 2 1869

7-AGE 54 3 19 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Geo Mese

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Mary Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) J C Rauman

(Address) 1132 W Cross St

15- Robert F. Harrison,

Filed JAN 21 1924 192 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 21-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 24, 19.. to Jan 21 24, 19.. that I last saw h alive on Jan 21 24 and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) John G Schwenker M D

, 19 (Address) 1126 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Jan 24, 19 24

20-UNDERTAKER. Jno. Wm. John W. Teufel & Son — ADDRESS 801 W. Fayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82956

CERTIFICATE OF DEATH.

74-081 B 82956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Miller

(a) RESIDENCE NO. 1130 W. Hamburg ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Miller

6 DATE OF BIRTH (month, day, and year) Dec 1. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~##~~	56	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boatmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Geo. H. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know.

12 MAIDEN NAME OF MOTHER Mary Fagan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Annie E. Brambitt

(Address) 1130 W. ~~Fayette St.~~ Hamburg St.

15 Filed JAN 21 1924 Robert F. Morrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1924, to 1-21, 1924, that I last saw him alive on 1-21, 1924, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Norwood Wilson M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Jan 24 1924

20 UNDERTAKER Mrs Mrs. John H. Teufel & Son ADDRESS 801 W. Fayette

Burial Permit Clerk

...matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 32957

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-901 82957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 Jackson ST., 24 WARD)-

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones.

(a) RESIDENCE NO. 1825 Jackson. ST., WARD,
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-21-24

7 AGE — Years — Months — Days — If LESS than 1 day, 15 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER William Jones.

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Olive Burns

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant
(Address)

15 Filed JAN 22 1924, 19 [illegible] Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-20- , 1924, to 1-21 , 1924

that I last saw him alive on 1-21 , 1924

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

prematurity

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Susanne R. Parsons, M. D.

1-21-1924 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS JAN 22 19

JOHNS HOPKINS HOSPITAL

Dept. of Health, Wm. S. Wood

JAN 22 1924

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82958

CERTIFICATE OF DEATH.

124 D 82958

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2413 E Chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Myers

(a) Residence No. 2413 E Chase St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 26 1842

7-AGE. 82 yrs. — mos. — ds.

If LESS than 1 day. ....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14- (Informant) John Conway

(Address) Lakeland Md

15- Filed JAN 2 1924 Robert P. Harrison, Registrar.

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 20-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 19 24 to Jan 20 19 24

that I last saw h.. alive on Jan 20 19 24

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial nephritis

(Duration) yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D

1/21, 1924 (Address) 733 Arlington Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Jan 23 19 24

20-UNDERTAKER. Wm Cook ADDRESS 502 E North Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Vans 918 E. Biddle St.

D 82959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82959

CERTIFICATE OF DEATH.

REGISTERED NO. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Brentwood Ave. ST., 10 WARD)

2-FULL NAME Frank B. Shever (Schurr)

(a) RESIDENCE NO. 1014 Brentwood Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 56 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Shever.

6 DATE OF BIRTH (month, day, and year) April 21-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker.

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard Shever

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Angela Taphorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna L. Shever
(Address) 1014 Brentwood Ave.

15 JAN 22 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-20, 1924, to 1-21, 1924, that I last saw h[illegible] alive on 1-21, 1924 and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobaris

..... (duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [redacted] D Bernstein M. D.

1/21, 1924 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Jan. 23 1924

20 UNDERTAKER Lilly & Zeiler ADDRESS 402 E Wolfe

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 82960

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 Peal ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Curtis

(a) RESIDENCE NO. 316 Peal ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Color	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 17th, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	15	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer) Sch

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jesse Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Francis Gaither

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Foster Parents (Address) 316 East Pratt

15 Filed . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21st 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26th, 1923, to Jan. 21st, 1924, that I last saw h— alive on Jan. 21st, 1924 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pul. tuberculosis,

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Fer Ellis, M. D.

(Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-23 1924

20 UNDERTAKER Dan'l Eachon

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

D 82961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82961

CERTIFICATE OF DEATH.

101-006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Wilkens Ave ST., 14 WARD)

2-FULL NAME Mrs. Anna Alrich

(a) RESIDENCE No. 1506 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Alrich

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE 33 Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wm Alrich 1506 Argyle Ave City

15 Filed ....., 19 Robert F. Harrison, Registrar

JAN 27 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/14, 1924, to 1/24/24, 19.....

that I last saw h[illegible] alive on 1/21/24, 19.....

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia (Rb)

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys & Lab

(Signed) H V Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 1-24 1924

20 UNDERTAKER: Samuel Easton

ADDRESS 916 Pa ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 82962

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 82962

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Vincent St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola ~~Edmonds~~ Henderson (J.T.H.)

(a) RESIDENCE NO. 1418 Vincent St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colred	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (J. T. H.)

6 DATE OF BIRTH (month, day, and year) about ~~1854~~ 1905 (J. T. H.)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~69~~ 19			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. H. Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John T. Thomas 1418 Vincent St.

15 JAN 21 1924, 192 Robert P. harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Cor (Inquest, autopsy or inquiry.) find that said deceased came to Cor death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan. 21, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Wm. T. Ashmun	1-23. 1924
20 UNDERTAKER Smith Earnest	ADDRESS 916 Pac ave

INSTRUCTIONS—AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 82963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82963

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3412 Seneca St. 13 WARD)

2-FULL NAME Joanna Allport

(a) RESIDENCE NO. 3412 Seneca ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Allport

6 DATE OF BIRTH (month, day, and year): Sept 12 1856

7 AGE: Years 67 Months 4 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Alexander Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): John Allport 3412 Seneca st

15 Filed JAN 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-4, 1924, to 1-22, 1924, that I last saw h-- alive on 1-22 1924, and that death occurred, on the date stated above, at 8 30 A.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Lagrippe Pneumonia

(duration) yrs. mos 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) C J Lingo M. D.

(Address) 2 Rockrose

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Jan 25 1924

20 UNDERTAKER: OHLENDWETH & SON, ADDRESS 3617 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 82964

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35-56 Poole ST., 13 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob W Gore

(a) RESIDENCE NO. 35-56 Poole ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily K Gore

6 DATE OF BIRTH (month, day, and year) Aug 10 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .. min.
	80	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Phillip Gore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anos Barnes (Address) 35-56 Poole St

15 Filed ..... 19 ..... Registrar

N 2 1924

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7th, 1924, to Jan 21st 1924

that I last saw him alive on Jan 20th 1924

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hydrothorax & Edema

(duration) ... yrs. ... mos. 30 ds.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [signature] M. D.

Jan 21, 1924 (Address) 846 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gist Carroll Grove Co DATE OF BURIAL Jan 23 1924

20 UNDERTAKER CHENOWETH & SON, ADDRESS 907 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 82965 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82965

90

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 Scott St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sigrid Dorsey

(Residence in Baltimore: No. 515 Scott St.; yrs.....mos.....ds.)

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Dec (Month) 14 (Day) 1864 (Year)

7-AGE, 59 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John A. Hunt

11-BIRTHPLACE OF FATHER, (State or Country). Balto Co Md

12-MAIDEN NAME OF MOTHER. Sarah E Burton

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rhoda Hyatt

(Address) 515 Scott St

15-

JAN 21 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 22 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

.....(Duration) .....yrs. about time mos.....ds.

CONTRIBUTORY (Secondary) Heart Block

.....(Duration) .....yrs. 5 mos.....ds.

(Signed) H K Bond M. D. (Coroner.)

1-22-, 1924. (Address) 1000 Eastern Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore County. DATE OF BURIAL, Jan 25, 1924

20-UNDERTAKER. Mrs. J. Tickner Sons ADDRESS Wolfe & Penn Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82966

CERTIFICATE OF DEATH.

74 001 D 82966

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Huntingdon ST., 17 WARD)

2-FULL NAME Mary Jane Riley

(a) RESIDENCE No. 2026 Huntingdon ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 72 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther C. Riley

6 DATE OF BIRTH (month, day, and year) Sept 22 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	72	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles W Duncan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Sunderland

13 BIRTHPLACE OF MOTHER (city or town) York Co
(State or country) Pa

14 Informant David Riley
(Address) 2026 Huntingdon

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

JAN 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22 1923, to Jan 22 1924
that I last saw her alive on Jan 22 1924
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm Hammerbacher M. D.

Jan 22 1924 (Address) 1421 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 23 1924

20 UNDERTAKER Wm F Kuhner & Son ADDRESS North Ave

INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82967

CERTIFICATE OF DEATH.

129 D 82967

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2436 Edmondson Ave St. 16 WARD)

2-FULL NAME Mary Hardcastle

(a) RESIDENCE NO. 2436 Edmondson Ave St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 4- year unknown

7 AGE: Years (about) 82 | Months 0 | Days 0 | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unknown.

(b) General nature of industry, business, or establishment in which employed (or employer): none.

(c) Name of employer: none.

9 BIRTHPLACE (city or town) (State or country): Centreville Ind.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Centreville Ind.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Centreville Ind.

14 Informant: Mollie Riley
(Address): 2436 Edmondson ave,

Filed JAN 2 1924 19.... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 21- 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1920, to January 21, 1924, that I last saw her alive on January 7—, 1924, and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) unknown. yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Signs + urine

(Signed) Chester Riland, M. D.

1-21. 1924 (Address) 2537 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem DATE OF BURIAL: Jan 23, 1924

20 UNDERTAKER: Wm Hickner & Son ADDRESS: North Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and old state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82968

CERTIFICATE OF DEATH.

129 D 82968

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3815 Katherine St., 15 WARD)

2-FULL NAME John Austin Roberts

(a) RESIDENCE No. 3815 Katherine ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vivian B. Roberts

6 DATE OF BIRTH (month, day, and year) Feby 16 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Sharp & Dohme

9 BIRTHPLACE (city or town) .....
(State or country) Delaware

PARENTS

10 NAME OF FATHER Jonathan B. Roberts

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Penna

12 MAIDEN NAME OF MOTHER Dora Emmons

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Delaware

14 Informant Vivian B. Roberts
(Address) 3815 Katherine ave

15 FEB 2 1924 Robert P. Harrison, M.D.
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21/ 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 21, 1924, that I last saw him alive on Jan 21, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Usual Clinical Findings

(Signed) ..... M. D.

. 19 (Address) 827 N. Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Del	Jany 23 1924
UNDERTAKER J. F. Pierce & Sons	ADDRESS Northeast

IMPORTANT—THIS IS A PERMANENT RECORD. Every question should be carefully answered, with unfading ink. Every statement should be stated EXACTLY. PHYSICIANS should be careful that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82969

D 82969

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 - Myrtle av ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas H. Middleton

(a) RESIDENCE NO. 421 - Myrtle av ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Middleton

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	—	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Henry Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Louise —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mamie Ford

(Address) 421 Myrtle av

15 JAN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1924

17 I HEREBY CERTIFY, That I attended deceased from January 13, 1924, to January 20, 1924, that I last saw him alive on January 20, 1924, and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Mitral regurg Valvular

(duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Goldmann, M. D.

1/23 24 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL 1/23 1924

20 UNDERTAKER Edward J. Hawley.

ADDRESS 538 N Eddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 32970

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 82970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... San Francis .....

(a) Residence No... B.V.A. ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1861

7-AGE. 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Francis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant) Municipal Hospital Record

(Address).....

13- JAN 23 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 12, 19 24 to January 20 19 24

that I last saw him alive on January 19 19 24

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ob

(Signed) Claude A. Dixon, M. D

1-21-19 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Cathedral	Jan 23 1924
20-UNDERTAKER,	ADDRESS
Mrs R. G. Elliott	725 Lanvale

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82971 ✓ 11-00 D 82971

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 N. Mount St.: 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Stanley Waters

(a) RESIDENCE. No. 1424 N. Mount St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co., Va.

12 MAIDEN NAME OF MOTHER Virgie Rebecca Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co. Va.

14 Informant Wm Waters
(Address) 1424 N. Mount

15 Filed JAN 23 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 21, 1924, that I last saw h. alive on Jan 21, 1924, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) John C. I. Campen, M. D.

1-21, 1924 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kylmonic Co	Jan 23 1924
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82972

CERTIFICATE OF DEATH.

5

101 001 D 82972

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 N. Eden ST., 5 WARD)

2-FULL NAME John Edward Lockley

(a) RESIDENCE No 628 N. Eden ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Wodower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) King & Queen Co
(State or country) Va

PARENTS

10 NAME OF FATHER David Lockley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant John Sogers (Cousin)
(Address) 623 N. Eden

15 Filed JAN 23 1924 BERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Pullen, M. D.
(Coroner.)

Jan 23 24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry Cemetery	Jan 23 1924
20 UNDERTAKER Edward Dyer	ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

82973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82973

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Abbottston ST., 9 WARD)

2-FULL NAME George Kampes

(a) RESIDENCE NO. 1709 abbottston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Anna Martha Kampes

6 DATE OF BIRTH (month, day, and year): July 4th 1844

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna M Flaykart

(Address) 1709 abbottston st

15 JAN 23 1924 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Jan 21, 1924, that I last saw h.im alive on Jan 21, 1924, and that death occurred, on the date stated above, at 10.5 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) F. J. Kinzley, M. D.

1/22, 1924 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 24th 1924

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 82974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2925 Frederick ST. 20 WARD)

2-FULL NAME David L. Wagoner

(a) RESIDENCE NO. 2925 Frederick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Entire mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Wagoner

6 DATE OF BIRTH (month, day, and year) Jan 27 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Painter

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Paints & Dealer~~

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster Md

(State or country)

PARENTS

10 NAME OF FATHER Elijah Wagoner

11 BIRTHPLACE OF FATHER (city or town) Not known

(State or country)

12 MAIDEN NAME OF MOTHER Mary Blubaugh

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania

(State or country)

14 Informant Mrs John H. Powell

(Address) 2925 Frederick Ave

15 JAN 23 1924 ROBERT A. KINSTLER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Jan 21, 1924, that I last saw h... alive on Jan 21, 1924, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Anemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) Not known mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jan M. D.

. 19 (Address) 222 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Md via Auto

DATE OF BURIAL Jan 24 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

I.C.D.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 90 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Aaron

(a) RESIDENCE No. 103 Warren ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Julia Aaron

6 DATE OF BIRTH (month, day, and year) Mar 23 1846

7 AGE: Years 77 | Months 10 | Days 30 | If LESS than 1 day, ..hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Poultry Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Marcellus Aaron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Emily Fall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Hosp. Records (Address)

Filed JAN 2 3 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-19 1924 to 1-22 1924

that I last saw him alive on 1-20 1924

and that death occurred, on the date stated above, at 11.05 A.M.

The CAUSE OF DEATH* was as follows:

(1) Left inguinal hernia

(2) Intracardial insufficiency

(3) Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1-21-24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) R. Dorsey M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Jan 25 1924

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101 001 D 82976

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Warner ST., 21 WARD)

2-FULL NAME Carrolton Turner

(a) RESIDENCE NO. 1013 Warner ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. 9 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov - 2 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Island
(State or country) maryland

PARENTS

10 NAME OF FATHER Joshua Turner

11 BIRTHPLACE OF FATHER (city or town) Kent Island
(State or country) maryland

12 MAIDEN NAME OF MOTHER Clara Robinson

13 BIRTHPLACE OF MOTHER (city or town) Kent Island
(State or country) maryland

14 Informant Clara Turner
(Address) 1013 Warner St

Filed JAN 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1924, to Jan. 21, 1924, that I last saw him alive on Jan. 20, 1924, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) - yrs. - mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm Swarm M. D.

1/22 1924 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1/23 1924
20 UNDERTAKER	ADDRESS
Jos. A. Farrell	2319 Division St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHOTOGRAPH • AFTER

D 82977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1521 W Fayette St. 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Stumbo

(Residence in Baltimore: No. 1521 W Fayette St.; yrs., 46 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Aug (Month) 15 (Day) 1877 (Year)

7-AGE. 46 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber - Mfr
(b) General nature of industry, business, or establishment in which employed (or employer): Maker

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Daniel F Stumbo

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Annie M Dougherty

13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W R Stumbo

(Address) 1521 W Fayette St

15. JAN 2 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 12 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Acut Alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Extreme Effluenz

to the cold (Duration) yrs. mos. ds.

(Signed) James H Penton M. D.
(Coroner.)

Jan 12 1924 (Address) 701 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, WESTERN CEM

DATE OF BURIAL, 1/24 1924

20-UNDERTAKER. ROBERT BROOKS SON

ADDRESS CORNER CALHOUN HOLLINS ST

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec.—1-10-21—M&T—1500 Blks.

D 82978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82978

CERTIFICATE OF DEATH.

X 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David J Gray

(a) RESIDENCE NO. Greenfield, Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Head

6 DATE OF BIRTH (month, day, and year) September

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mrs. L. D. Drewry

(Address) Deabruzz, Florida

15 FUNERAL DIRECTOR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1924, to Jan. 22, 1924, that I last saw him alive on Jan. 22, 1924, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Colon - inoperable
Post - operative cerebral embolus - (ileocolostomy on 1-15-24)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-15-24

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) M. Alexander Lovely, M. D.

, 19 (Address) St. Agnes' Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenfield, Ohio

DATE OF BURIAL 1/23 1924

20 UNDERTAKER Henry W. Means & Son

ADDRESS 805 N. Calvert St.

Registrar

JAN 23 1924

Via B. & O. R.R. - Mrs. L. D. Drewry & escort.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82979

CERTIFICATE OF DEATH.

38 D 82979

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital (WARD)

2-FULL NAME John Doe (Henry Baro)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unkn.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital

JAN 23 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1924, to Jan. 20, 1924, that I last saw him alive on Jan. 20, 1924, and that death occurred, on the date stated above, at 4. a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis
Luetic Infection
Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Term. Bronchopneum.
1 (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic & Lab

(Signed) H. D. Arnold, M. D.

, 19 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 23 1924

20 UNDERTAKER

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 82980

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 D 82980

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 10 WARD)

2-FULL NAME Evelyn Platt

(a) RESIDENCE No. 505 Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

S. Life

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Platt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 JAN 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1927, to Jan. 22, 1924, that I last saw h e alive on Jan 22, 1927, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Isidor I. Jaffe M. D.

Jan 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rock Road	Jan 23 1924
20 UNDERTAKER Jack Lewis 1439 E Balto St	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Otitis Media

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 of B 82931

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 S. Stockton ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. A. Ruff

(a) RESIDENCE. No 123 S. Stockton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 18 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Market Stalls

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Joseph Ruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Susan Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs Ruff

(Address) 123 Stockton

15 Filed JAN 23 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1924

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1924, to January 21, 1924, that I last saw h alive on January 19, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Egnatz Dell M. D.

Jan 23 1924 (Address) 1433 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Jan 23 1924
20 UNDERTAKER	ADDRESS
Hartfields	1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 82982

CERTIFICATE OF DEATH.

101-001

B 82982

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Maryland Ave ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Pillott

(a) RESIDENCE. No. 1717 Maryland Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
15				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charlotte County Va

PARENTS

10 NAME OF FATHER Joseph Pillott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Kattie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Kattie Pillott
(Address) 1717 Maryland Ave.

15 Filed JAN 23 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 19 24, to Jan 19, 19 24, that I last saw her alive on Jan. 19, 19 24, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood & Sputum

(Signed) L. A. Johnson M. D.

19 (Address) 211-E-23rd St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Jan 24 1924

20 UNDERTAKER Cofer & Alexander ADDRESS 5-26 Druid Hill Ave Balto

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82983

CERTIFICATE OF DEATH.

38 D 82983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Gilmor 19 WARD)

2-FULL NAME Samuel D. Maurice

(a) RESIDENCE NO. 509 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
40	40	3	01	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Joseph Maurice

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD.

12 MAIDEN NAME OF MOTHER Jennie Opher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD.

14 Informant Irma Maurice

(Address) 509 N. Gilmor St.

Filed JAN 23 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1923, to Jan. 20, 1924, that I last saw h alive on Jan. 20, 1924, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis Syphilitic

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. 2 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Jno. M. Hayes, M. D.

1/25, 1924 (Address) 513 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: John N. Toadvine — ADDRESS 142 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-24-10—M. & T.—2000 Bks.

U 82984 HEALTH DEPARTMENT—CITY OF BALTIMORE U 82984

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Comegys.

(Residence in Baltimore: No. 2106 Eutaw St.; 64 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): widow

6-DATE OF BIRTH, ... (Month) Jan (Day) 1 (Year) 64

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Geo Brown

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Luhman

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louisa Comegys

(Address) 2217 Penna Ave

15- FILED JAN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 24, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 19th 1924, to Jan 20 1924, that I saw her alive on January 19 1924 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Heart Disease

Valvular

General Paresis

(Duration) ....yrs. ....mos., ...ds.

CONTRIBUTORY (Secondary) Acute Indigestion 12 hours

(Duration) ....yrs. ....mos. ....ds.

(Signed) Emmett Flynn M. D.

Jan 23, 1924 (Address) 2237 N Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Zion

DATE OF BURIAL, Jan 23 1924

20-UNDERTAKER John H Toadvine

ADDRESS 142 Eutaw St

Spec.—1-10-21 M&T 1500 Bks.

1698 16 82985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82985

X49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Adolph Schwartz

(a) RESIDENCE NO 1127 Jenny Lind St. ST. Gwynns WARD Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Rosie Schwartz

6 DATE OF BIRTH (month, day, and year) Nov 15, 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Ins Agent

(b) General nature of industry, business, or establinhment in which employed (or employer) Life Ins Co

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Austrian

PARENTS

10 NAME OF FATHER Bernard Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austrian

12 MAIDEN NAME OF MOTHER Fannie Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austrian

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 JAN 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Jan 22, 1924.

that I last saw him alive on Jan 12, 1924.

and that death occurred, on the date stated above, at 10 55 A. m.

The CAUSE OF DEATH* was as follows:

Malignant Kidney tumor

(duration) 12 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 16 1924

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw M. D.

(Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL McKeesport Pa DATE OF BURIAL Jan 23 1924

20 UNDERTAKER Jack Louis ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16 1231

D 82986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D 82986

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. No. ST., 7 WARD)

2-FULL NAME James Brown

(a) RESIDENCE No. Hollywood, St Marys County Maryland

(Usual place of abode)

Length of residence in city or town where death occurred 3 mos. How long in U. S., if of foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs James Brown

6 DATE OF BIRTH (month, day, and year) Oct 10 1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman fo

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barbara Pigg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 23 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923 to Jan 21, 1924 that I last saw h.. alive on Jan 21, 1924 and that death occurred, on the date stated above, at 8 10 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lung
Metastases to liver, adrenals, brain, etc.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Pennsylvania

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 1/25 1924

20 UNDERTAKER George J Ruth — ADDRESS 1737 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1000 Blks.

D 82987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 82987

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 16 WARD)

2-FULL NAME Rosemary Kerr

(a) RESIDENCE No. 611 Linnard St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

8a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Kerr

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Rosemary Hess

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Records (Address)

15 JAN 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/22/24

17 I HEREBY CERTIFY, That I attended deceased from 1/17/24, 19..., to 1/22/24, 19...

that I last saw her alive on 1/22/24, 19...

and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

Double Mastoiditis

Sinus Thrombosis

..... (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

..... (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bilateral Mastoid

Did an operation precede death? Yes Date of 1/21/24

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) H. W. Holley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Cathedral Jan 26	1924
20 UNDERTAKER	ADDRESS
Williams Cook	502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82988

CERTIFICATE OF DEATH.

N 129

D 82988

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3602 Fait ave St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kappel

(a) Residence No. 3602 Fait ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, ~~HUSBAND of (or)~~ WIFE of Louis Kappel

6-DATE OF BIRTH (month, day and year) Dec. 3-1849

7-AGE. 74 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, George Gapl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14-

(Informant) Mrs P. Spann

(Address) 3602 Fait ave

JAN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Janry 17 1924 to Jany 20 1924 that I last saw her alive on Jany 20 1924 and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arterial Sclerosis

(Duration) 1 yrs. Or More mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar V Athey, M. D.

Jan 24 1924 (Address) 100 S. Patterson Park ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel — DATE OF BURIAL, Jan 24 1924

20-UNDERTAKER. Burkhardt & Birkelbach — ADDRESS 1739 Eager

IMPORTANT—PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 32989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 ✓

D 32989

1-PLACE OF DEATH

City of BALTIMORE: (No. 3214 Hudson St., 76 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Davies

(a) Residence No. 3214 Hudson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Davies

6-DATE OF BIRTH (month, day and year) April 21-1868

7-AGE. 55 yrs. 9 mos. — ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Henry Milke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Isabelle Hutson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Alfred Davies

(Address) 3214 Hudson St.

15- Filed JAN 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 21-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Jan 21, 1924

that I last saw h alive on Jan 21, 1924

and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Horace B Sutton M. D.

1/22, 1924 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, Jan 25, 1924
Oaklawn	
20-UNDERTAKER Kirkland Kirkland	ADDRESS 1739 Eager

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82990

CERTIFICATE OF DEATH.

170 D 82990

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 E. 33rd St ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. King

(a) RESIDENCE No 612 E. 33rd. St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Malee	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Jan 26/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Insurance
(b) General nature of industry, business, or establishment in which employed (or employer): Salesman
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Patrick J. King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Irel and

12 MAIDEN NAME OF MOTHER: Leila Tootel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Thersa Ferguson
(Address) 612 E.33rd St

15 Filed JAN 23 1924 192 ROBERT P. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal & Thoracic Hemorrhage
Pistol Shot wounds-self inflicted
(Suicide)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Collins, M. D.
(Coroner.)
Jan 21/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 24 1924
20 UNDERTAKER Richard F. Cluley	ADDRESS 1108 Guilford Ave.

Spec.—1-10-21—M&T—1500 Blks.

D 82991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 82991

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 N Fulton Ave ST. 16 WARD)

2-FULL NAME Margaret M Shuesmann

(a) RESIDENCE NO. 1706 N Fulton Ave ST., N. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Frederick K Shuesmann

6 DATE OF BIRTH (month, day, and year): Sept 4 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Mt Pleasant Township Adams Co. Pa.

PARENTS

10 NAME OF FATHER: Peter Brightmire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mt Pleasant Township Adams Co. Pa.

12 MAIDEN NAME OF MOTHER: Margaret Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Peter L Shuesmann
(Address): 913 Bennett Pl

15 JAN 2 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1924 to Jan 21 1924, that I last saw h alive on Jan 21 1924, and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis and Cardiac Dilatation

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Myocarditis, & Uterine Cancer over

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Kenneth Cookman M. D.

1924 (Address) 203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jany 24 24

20 UNDERTAKER: Wm J Hartwell ADDRESS 2236 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82992

CERTIFICATE OF DEATH.

90 D 82992

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1900 E. Oliver St. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Ogden Buckle Jr.

(a) Residence No. 1900 E. Oliver St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 12, 1873

7-AGE,	If LESS than 1 day,
50 yrs. 5 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Philadelphia Pennsylvania

PARENTS.

10-NAME OF FATHER, William Buckle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Estelle Ball

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14-

(Informant) Charles R. Buckle

(Address) 1900 E. Oliver St.

15-

Filed ..... 192.....

JAN 23 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1923 to Jan 21 1924

that I last saw him alive on Jan 21 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) William France M. D.

1-22-1924 (Address) 1407 N. Gay St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cem	Jan 24 1924
20-UNDERTAKER,	ADDRESS
Joseph L. Cook	1003 N. Gay St

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82993 HEALTH DEPARTMENT—CITY OF BALTIMORE D 82993

21

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Fleming

(a) RESIDENCE NO. 603 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luke Fleming

6 DATE OF BIRTH (month, day, and year) July 27-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Samuel Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Ann [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant James P. Fleming Sr. (Address) 603 N. Carey St.

15 Filed JAN 23 1924, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1924, to Jan 22, 1924, that I last saw her alive on Jan 21, 1924, and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Erysipelas.

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic.

(duration) — yrs. — mos. ? ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B. MacGowan, M. D.

1/22/24 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernport Md.	Jan 24 192
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Borchers)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82994

D 82994

CERTIFICATE OF DEATH.

74-00

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Appleton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gesina Margaret Borchers

(Residence in Baltimore: No. 1810 Appleton St. St.; 38 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 12, 1844
(Month) (Day) (Year)

7-AGE, 79 yrs. 9 mos. 10 da.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 027

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Herman Otken

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Bek Hajen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Borchers

(Address) 1810 Appleton St

15- JAN 23 1924

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1924, to Jan 23 1924, that I saw her alive on Jan 22 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 1 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 4 yrs. ..... mos. ..... da.

(Signed) Chas A. Schaefer M. D.

Jan 23, 1924. (Address) 1153 W Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Jan 24, 1924

20-UNDERTAKER J. B. Kleppert

ADDRESS 2256 Frederick Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 82995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82995

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3605 E. Pratt St. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Wolf.

(a) RESIDENCE. No. 3605 E. Pratt ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of = Married 2

6 DATE OF BIRTH (month, day, and year) July 5th 1850

7 AGE: 73 Years; 6 Months; 15 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Wolgemuth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma Holt

(Address) 3605 E. Eager St

15 Filed JAN 23 1924 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1923, to Jan 23, 1924

that I last saw h[illegible] alive on Jan 23, 1924

and that death occurred, on the date stated above, at 9 10 m.

The CAUSE OF DEATH* was as follows:

1 Coma Convulsions

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Selby M. D.

Jan 31, 1924 (Address) 3525 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Jan 25 1924

20 UNDERTAKER: F. D. Wippert — ADDRESS: 2236 Fredk Ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 82996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82996

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Askew St. ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bell

(a) RESIDENCE No. 1407 Askew St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Sept. 24. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
41	years	3.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Daniel Bell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Irene Bell

(Address) 1407 Askew St.

15 Filed JAN 23 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26 . 1923 . to Jan 18 . 1924.

that I last saw h[illegible] alive on Jan 18 . 1924.

and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of urine

(Signed) Carl L. Greckman, M. D.

1-21. 1924 (Address) 1210 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery Jan 23.	1924
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 23 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 82997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 82997

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1159 Riverside Ave St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Sander

(a) Residence No. 1159 Riverside Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 9. 1839

7-AGE. 84 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Milk Dairy

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 Yrs

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Peter Sander

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Barbara A. Hertz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant) Mrs Jennie Browning

(Address) 1159 Riverside Ave

15-

JAN 23 1924 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 21 24

17- I HEREBY CERTIFY, That I attended deceased from 10-3 1924 to 1-21 1924

that I last saw him alive on 1-21 1924

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis.

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic nephritis - chronic myocarditis (Duration) 10 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Sign

(Signed) James Brown M. D

, 19 (Address) 1319 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Olivet Cem.	Jan. 24 1924
20-UNDERTAKER.	**ADDRESS.**
H. Sander Sons	1710 Fleet St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82998

CERTIFICATE OF DEATH.

31

D 82998

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Aisquith ST., 9 WARD)

2-FULL NAME Anna Osel

(a) RESIDENCE No. 2023 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Osel

6 DATE OF BIRTH (month, day, and year) Dec 30 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Sebastian Hoffmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Osel

(Address) 2023 Aisquith St

15 Filed ..... 19 Robert F. Harrison, Registrar

JAN 23 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Jan 21, 1924, that I last saw h[illegible] alive on Jan 20, 1924, and that death occurred, on the date stated above, at 10 48 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

from [illegible] (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C A Mayhew M. D.

Jan 22 1924 (Address) 3100 Harford Ry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C.A. Co.	1-24 1924
20 UNDERTAKER	ADDRESS
Ehrs Nash	115 E West St

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 82999

3/V 82999

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2800 Riggs Ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Cross

(a) RESIDENCE No. 2860 Riggs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6 1893

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
30	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer) C & P Tel. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John H Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Julia A Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John H Cross

(Address) 2800 Riggs ave

15 Robert P. Harrison, 19

Registrar

Burial Permit Clerk.

JAN 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22nd 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Jany 22 1924.

that I last saw h.. alive on Jany 22, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

1/23, 1924 (Address) 108 W Fayette Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 1-25 1924

20 UNDERTAKER James Dignan & Son

ADDRESS 5 Pac Pl.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83000

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 83000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3819 Belair Rd. ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mueller.

(a) RESIDENCE NO. 3819 Belair Rd. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Mueller.

6 DATE OF BIRTH (month, day, and year) March 5-1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Mueller.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Carrie Rutledge (Address) 3819 Belair Rd.

15 Filed JAN 2 31924 Robert P. Harrison Registrar

Burial Permit 83...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to Jan 20, 1924.

that I last saw h lived alive on Jan 20, 1924

and that death occurred, on the date stated above, at 12.00 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible] M. D.

1/22/1924 (Address) Mayfield - Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Jan. 24 1924

20 UNDERTAKER Lilly and Zeiler. ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83001

CERTIFICATE OF DEATH.

91-02

D 83001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Jackson ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Beziat

(a) RESIDENCE. NO. 1629 Jackson. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Jas. Beziat

6 DATE OF BIRTH (month, day, and year) Jun 26. 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	11.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va

PARENTS

10 NAME OF FATHER James Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Leroy Va

12 MAIDEN NAME OF MOTHER Catherine Atkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant Mrs Selby

(Address) 1629 Jackson

15 Filed JAN 23 1924

16 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1924, to Jan 21, 1924, that I last saw h~~e~~r alive on Jan 20, 1924 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis with Hypertension

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Sidney H. Streett, M. D.

1/24, 1924 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsburg W. Va.	1/24/ 1924
20 UNDERTAKER	ADDRESS
E. J. Fanning Inc	1460 Battery Ave

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83002

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83002

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Glover ST., 6 WARD)

2-FULL NAME Bernard Goor

(a) RESIDENCE NO. 408 N Glover St ST., 7 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Michael Goor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mathilda Goor

(Address) 408 N Glover

15 JAN 23 1924 Robert P. Harris

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1924 to Jan 22, 1924 that I last saw h[illegible] alive on Jan 22, 1924 and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

a Broncho Pneumonia

(duration) 3 days

CONTRIBUTORY (Secondary) Pneumonia Edema

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Levert, M. D.

1/22, 1924 (Address) 413 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Jan 24 1924

20 UNDERTAKER: Stephen J Gralkowski — ADDRESS: 1005 S Kenwood Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83003 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83003

CERTIFICATE OF DEATH.

187-007

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md. General Hospital ST. 13 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicholas Fischer

(Residence in Baltimore: No. 1322 Weldon Ave. St. 7 yrs., mos., ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Oct. (Month) 18 (Day), 1858 (Year)

7-AGE, 65 yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Millwright on Radiators
(b) General nature of industry, business, or establishment in which employed (or employer): Republic Radiator Co.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Fischer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna —

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. M. Fischer

(Address) 1322 Weldon Ave.

15- Robert P. Harrison, Registrar.

JAN 23 1924

191 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 21 (Day), 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of R. Femur accidental (caught in belt of Republic Radiator Co.) (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchs - Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 24, 1924 (Address) 7802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. d

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Manchester Md. DATE OF BURIAL, Jan. 24, 192

20-UNDERTAKER Horace M. Burgee ADDRESS 1631 Fallsway

D 83004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83004

CERTIFICATE OF DEATH.

181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1235 Spring Mount Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Simmont

(Residence in Baltimore: No. 1235 Spring St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Mal

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Nov (Month) 9 (Day) 1869 (Year)

7-AGE: 54 yrs. mos. 2 ds. 13

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Brick Manufac,

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: David Simmont

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore, Md,

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W Simmont Jr

(Address) 1235 Spring St

15-

Filed JAN 23 1924, 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (22) Jan (Month) 7th (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas, Accidental

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fenlon M. D. (Coroner.)

Jan 12, 1924 (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: Jan 25 1924

20-UNDERTAKER: Jos Jacobs & Son ADDRESS: 2178 Pac.

8—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 83005

HEALTH DEPARTMENT—CITY OF BALTIMORE D 83005

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 E 28th St., St.: 9 WARD)

2-FULL NAME Edward Leo Kelly

(a) RESIDENCE. No. 1801 E 28th St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/15/18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	-	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John C Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Gertrude McNerney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Jno C. Kelly. (Address) 501 - 28th. St.

15 1924 JAN 23 19

Robert P. Harris.

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1924, to Jan 23, 1924, that I last saw h... alive on Jan 23, 1924, and that death occurred, on the date stated above, at 12,45 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) Edw. L. Zimmerman M. D.

(Address) 2858 Hanford Rd 1/23 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: 1/25 1924

20 UNDERTAKER: J. F. Lahey & Son ADDRESS: 318 Fulton Ave

JAN 23 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83006

CERTIFICATE OF DEATH.

X 60-00

D 83006

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Rogers

(a) RESIDENCE NO. Cox's Mills, Box 41 ST. Route 2 WARD Creston, Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) ? 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Kenan Seasel

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JAN 23 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1923, to Jan. 23, 1924, that I last saw her alive on Jan. 23, 1924, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Thyroid Intoxication, acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hyperthyroidism and Myocardial Disease (duration) 6-8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? W Va

Did an operation precede death? yes Date of Jan 23-1924

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Julian D Hart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gilmer Shaban Va — DATE OF BURIAL Jan 27 1924

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exophthalmic Goiter

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83007

CERTIFICATE OF DEATH.

D 83007

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John W. Hawkins.....

(a) Residence No. 10 W. Biddle St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed.

5a-if married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1847

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town): ? (State or Country):

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town): ? (State or Country):

11. (Informant) Municipal Hospital Records

(Address)

JAN 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 5 19 24 to January 21 19 24

that I last saw h... im alive on January 21 19 24

and that death occurred, on the date stated above, at 6:00 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spleen

(Duration) yrs. 2½ mos. (History) ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude B. Thorn M. D

1-22- 19 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: 1/24 1924

20-UNDERTAKER: Arch Hanley

ADDRESS: 1 Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83008 — 75-001 — D 83008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 Chelsea Terrace ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Rebecca Voyts

(a) RESIDENCE No. 2122 Chelsea Terrace ST., 15 WARD Resident.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? 74 yrs. 9 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C. Voyts

6 DATE OF BIRTH (month, day, and year): April 6 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER: Jim Sheridan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Maryland

12 MAIDEN NAME OF MOTHER: Susanna Thorl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co. Maryland

14 Informant: Miss Mary Estelle Thurston (Niece)
(Address) 2122 Chelsea Terrace.

15 Date Received: JAN 24 1924 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1923, to Jan 21, 1924,

that I last saw her alive on Jan. 21, 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

*Gangrene Lt foot with infection + toxaemia.

(duration) 0 yrs. 1 mos 22 ds.

CONTRIBUTORY (Secondary) Lt hemiplegia

(duration) 0 yrs. 1 mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) S. A. Dreslin, M. D.

Jan 22 1924 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Camp Chapel Mem. Perry Hall Balto. Co. Md.

DATE OF BURIAL: Jan 24 1924

20 UNDERTAKER: MOWEN COMPANY
WILLIAM F. WOODEN, Successor

ADDRESS: 108 W. NORTH AVE.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83009

CERTIFICATE OF DEATH.

101-001 D 83009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 Welcome Al. ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Pryor. (C).

(a) RESIDENCE NO 135 Welcome ST., Al. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married.

5a If married, ~~widowed, or divorced~~ ~~(HUSBAND) of~~ (or) WIFE of Crawford Pryor. (C).

6 DATE OF BIRTH (month, day, and year) March 9, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co. Md.

PARENTS

10 NAME OF FATHER Charles Hollen. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Henrietta Brown. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Anne Co. Md.

14 Informant Henrietta Robinson. (C)(daughter)
(Address) 1105 Berkley Street.

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jan. 22. , 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 1-24 1923

20 UNDERTAKER John H. Toadvine — ADDRESS 143 Ostend St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KEEP SAFE

Spec.—1-10-21—M&T—1500 Blks.

D 83010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83010

CERTIFICATE OF DEATH.

+90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 719 St Mowrae ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marienne B Cumba

(a) RESIDENCE NO. 719 Monrae ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. 7 mos. ds.

(If non-resident give city or town and State) Jamaica

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex Cumba

6 DATE OF BIRTH (month, day, and year) Feb 5 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kingston Jamaica

PARENTS

10 NAME OF FATHER James J Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Isabella Hemingway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kingston Jamaica

14 Informant E. J. Thompson

(Address) 719 St Mowrae St

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1923, to Jan 23 1924, that I last saw h[illegible] alive on Jan 23 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows: Chronic Arthritis. Deformans.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Panama

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Arthritis Deformans

(Signed) Thos W Pyle, M. D.

(Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan 24 1924

20 UNDERTAKER Geo W Little — ADDRESS 2709 Edmondson Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

KODAK

Spec—1-10-21—M&T—1500 Bks.

83011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 83011

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S.Augusta Ave. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathilda Stahl,

(a) RESIDENCE No. 314 S.Augusta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Stahl,

6 DATE OF BIRTH (month, day, and year) August 1.1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lewis J.Emery,

(Address) 314 S.Augusta Ave

15 JAN 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1923, to Jan 23, 1924,

that I last saw h.alive on Jan 23, 1924

and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

General Arterial-Sclerosis

Contributory Old Age —

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W. Jones M. D.

Jan 24 1924 (Address) 222 Abg. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Jan 25 1924

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 83012

CERTIFICATE OF DEATH.

91-002 D 83012

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Hollins ST., 19 WARD)

2-FULL NAME Mary A. Nicholson

(a) RESIDENCE NO. 1707 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Nicholson

11 BIRTHPLACE OF FATHER (city or town) Kent County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla McComas.

13 BIRTHPLACE OF MOTHER (city or town) Kent County
(State or country) Maryland

14 Informant Miss Annie Nicholson
(Address) 1710 Hollins Street

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

JAN 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to Jan. 23, 1924, that I last saw her alive on Jan. 22, 1924 and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

about 5 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Duvall, M. D.

1/23, 1924 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 25 1924
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

21

D 83013

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 W. Hamburg Street St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline E. Otto

(a) Residence No. 1113 W. Hamburg Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Montzel Otto

6-DATE OF BIRTH (month, day and year) Dec. 10, 1864

7-AGE.	If LESS than 1 day,
59 yrs. 1 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Wilhelmina Strasser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mrs. J. Quinn

(Address) 1113 W. Hamburg St.

15-

Filed..... 192.....

JAN 24 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 18 1924 to Jan. 22 1924

that I last saw her alive on Jan. 21 1924

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

4
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

Unknown
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill M. D.

1-22-19 24 (Address) 108 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Jan 25 19 24
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83014

CERTIFICATE OF DEATH.

100-001

D 83014

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2856 Harford ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane A Foote

(a) RESIDENCE. No. 2856 Harford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: David E Foote

6 DATE OF BIRTH (month, day, and year): aug 24 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Conn.

PARENTS

10 NAME OF FATHER: Harvey Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn.

12 MAIDEN NAME OF MOTHER: Jannette Hurdurn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn.

14 Informant (Address): Ida M. Orem 106 Woodlawn Road

15 Filed JAN 24 1924 19

ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 22, 1924, that I last saw her alive on Jan 22, 1924, and that death occurred, on the date stated above, at 11.5 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. O. Zimmerman M. D.

1/23, 1924 (Address) 2355 Harford Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 24 1924

20 UNDERTAKER: John O Mitchell ADDRESS: 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 83015 HEALTH DEPARTMENT—CITY OF BALTIMORE (Malanowski) 188-003 D 83015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., V WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Malanowski

(a) RESIDENCE No. 232 S. Chester ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 27-1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	3 mo	28 days	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work News boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ft Davis
(State or country)

PARENTS

10 NAME OF FATHER Antoni Malanowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Rose Polanowski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Antony Malanowski
(Address) 232 E Chester st

15 JAN 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull

Accidentally struck by Auto

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Hurley, M. D.

(Coroner.)

Jan 24, 192 4 (Address) 1037 Hadary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

*Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan 26 1924

20 UNDERTAKER John A. Welsh ADDRESS 1803 Bank st

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 201 D 83016

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 John ST., 11 WARD)

2-FULL NAME Lucy Ellen McRae Rice

(a) RESIDENCE No. 1208 John ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr Chas Davis Rice

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1836

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 400

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Va

PARENTS

10 NAME OF FATHER Thomas McRae

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond

12 MAIDEN NAME OF MOTHER Sarah Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Mrs Mary S McKenzie

(Address) 1208 John St

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23 1924

17 I HEREBY CERTIFY, That I attended deceased from January 23 1924 to January 23 1924

that I last saw her alive on January 23 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy —

20 minutes —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis —

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Chas W. Lavenia, M. D.

Jan 23 1924 (Address) 1327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL 1-27 1924

20 UNDERTAKER Henry Trudeau & Son Co

ADDRESS Richmond

Cor.—1-12-23—M&T—100 Bks.

D 83017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

27 188-003 D 83017

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Hilcrest Ave & Old Harford Road ST., WARD)

2-FULL NAME Wilhelm H. Hochstedt

(a) RESIDENCE No 15 E. Hamilton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Hochstedt

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Florist 045
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Miss Bertha Hochstedt (Address) 15 E. Hamilton Ave

15 Filed JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia- due to lack of care & recum bency in bed since fracture of leg in July/24 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) remotely auto-accident (duration) yrs. mos. ds.

(Signed) [signature] (Coroner.), M. D.

Jan 22/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Jan 24 1924

20 UNDERTAKER John Ellicott — ADDRESS 200 E. Lexington

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Scarborough
1613 E North

283018 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-081 283018

1-PLACE OF DEATH

City of BALTIMORE: (No. 1841 N. Ch. Bond St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles S. Salisbury

(a) Residence No. 1841 N. Ch. Bond St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rose Salisbury

6-DATE OF BIRTH (month, day and year) March 16-1849

7-AGE, 75 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tool Sharpner

(b) General nature of industry, business, or establishment in which employed (or employer) Self 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Edward Salisbury

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Martha G Pennington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Rose Salisbury

(Address) 1841 N. Ch. Bond

15- Filed JAN 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 23/24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1924, to Jan. 23, 1924.

that I last saw him alive on Jan. 23, 1924

and that death occurred, on the date stated above, at 945 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Albert Klingenstein, M. D.

1/24, 1924 (Address) 163 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Cemetery DATE OF BURIAL, 1/26, 1924

20-UNDERTAKER Wm Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Hanover St

HEALTH DEPARTMENT—CITY Or BALTIMORE

D 83019

D 83019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1922 Riggs Ave

Registered No. 16 46

City of BALTIMORE: (No. ..... St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Rebecca Smoot

(a) Residence No. 1922 Riggs Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Female

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Irving B Smoot

6-DATE OF BIRTH (month, day and year) Sept 6 1873

7-AGE, 50 yrs. 9 mos. 16 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Samuel K Patterson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penna

12-MAIDEN NAME OF MOTHER Margaret Gillin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Irving B Smoot

(Address) 1922 Riggs Ave

JAN 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 22 1924

17-I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923 to Jan 22 1924

that I last saw h[illegible] alive on Jan 21 1924

and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma

Contr 2 y several

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) abdominal infection

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Microscopic

(Signed) C Hann, M.D.

, 19 (Address) 1215 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park

DATE OF BURIAL, Jan 25 1924

20-UNDERTAKER, Wm Cook

ADDRESS 502 E Fayette

d.—WRITE PLAINLY with pen and ink. Do not use lead pencil. All items must be answered or the word "unknown" or the letters "ca" (circa) inserted. Every certificate should be carefully supplied. AGE, OCCUPATION and CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83020

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1014 Aisquith ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Rebbert

(a) RESIDENCE No. 1014 Aisquith ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Martha M. Rebbert.

6 DATE OF BIRTH (month, day, and year) Aug. 27 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	59	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Theodore Rebbert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Fahner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant M. Theodore J. Rebbert.

(Address) 1014 Aisquith St.

15 JAN 24 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21 1923 to Jan 23 1924, that I last saw h[illegible] alive on Jan 23 1924, and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (D)

(duration) yrs. 7 mos. ? ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of No.

Was there an autopsy?

What test confirmed diagnosis? (D) None

(Signed) Owen Kellerman, M. D.

(Address) 938 Kleinert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 26 1924
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83021

100-09 D 83021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Monroe St. 25 Ward) Brooklyn

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Mary Grace

(a) RESIDENCE NO. 614 Cherokee St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21st 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER William L. Grace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie M. Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William L. Grace

(Address) 614 Cherokee St.

15 JAN 24 1924 ROBERT R. KRAETER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1924 to Jan 22 1924.

that I last saw her alive on Jan 22 1924.

and that death occurred, on the date stated above, at 8 2 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Penn M. D.

(Address) 614 Cherokee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Jan 24th 1924

20 UNDERTAKER E. Schloman & Son ADDRESS 1039 Hanover

Cor.—1-12-23—M&T—100 Bks.

D 83022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83022

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 S. Charles St. ST., 23 WARD)

2-FULL NAME Kim Sing Wong.

(a) RESIDENCE NO 1125 S. Charles St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Yellow.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~OR WIFE OF~~ Marie Wong.

6 DATE OF BIRTH (month, day, and year) November 20, 1868.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chinese Restaurant.
(b) General nature of industry, business, or establishment in which employed (or employer) Chef
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Marie Wong. (wife).
(Address) 1125 S. Charles St.

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Adam Bernhardt M. D.
(Coroner.)

Jan. 22, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	1/25 1924
20 UNDERTAKER J. F. McCully	ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83023

CERTIFICATE OF DEATH.

90 D 83023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Hanover St. ST., 23 WARD)

2-FULL NAME Mary B. Skuhr.

(a) RESIDENCE No. 1522 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 73 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or ~~divorced~~ HUSBAND OF ~~WIFE OF~~ (or) WIFE of Charles H. Skuhr.

6 DATE OF BIRTH (month, day, and year) Dec, 1, 1846.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Wistling.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Bertha Seume

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Matilda Schleicher (daughter)

(Address) 1522 Hanover St

JAN 24 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 23, 1924

17

I HEREBY CERTIFY, That I attended deceased from November 17, 1923, to January 23, 1924.

that I last saw her alive on January 22, 1924.

and that death occurred, on the date stated above, at 3.35 ~~P~~ a. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart and kidneys.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt M. D.

1/28 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 1/26 1924

20 UNDERTAKER L. F. McCauley

ADDRESS 190 E. Fort

Spec- 12-23-21—E.B.R.S.—400 Bks.

Transcript

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83024

CERTIFICATE OF DEATH.

12-2.002

D 83024

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.....661 Eleventh St..Morrell Park..Ward) 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Monroe Smith Jr.

(a) Residence No.....661 Eleventh St Morrell Park.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 12 1868

7-AGE.	If LESS than 1 day.
55 yrs. 6 mos. 10 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Locksmith 086

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER. Monroe Smith Sr.

11-BIRTHPLACE OF FATHER (city or town)...England
(State or Country).

12-MAIDEN NAME OF MOTHER. Catherine Jordan

13-BIRTHPLACE OF MOTHER (city or town)..Ireland
(State or Country).

11-

(Informant) Mrs. Catherine Wolf

(Address).....Morrell Park.....

15-

JAN 24 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 22 1924

17- I HEREBY CERTIFY, That I attended deceased from

Aug 13 1923 to Jan 22 1924

that I last saw him alive on Jan 21 1924

and that death occured, on the date stated above, at 4 Am.

The CAUSE OF DEATH* was as follows:

Cerrhosis of Liver

(Duration) Years 5 mos. ds.

CONTRIBUTORY None
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry A Bolo M. D

Jan 23. 1924 (Address) 208 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem.	1/24 1924
20-UNDERTAKER.	**ADDRESS**
I. F. McCauley	1306 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Non Alcoholic

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83025

CERTIFICATE OF DEATH.

D 83025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 So. Spring ST., 3 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Clayton

(a) RESIDENCE NO. 226 So. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): Washing

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Julian Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Pearl Carlson 226 So. Spring St

JAN 24 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1924. January 21, 1924.

that I last saw her alive on January 21, 1924.

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (coma)

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Paralysis Bright Disease (duration) ... yrs. 6 mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. S. W. Kennard, M. D.

1/28/1924 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury — DATE OF BURIAL: Jan 24 1924

20 UNDERTAKER: John W Henderson — ADDRESS 1502 E Monument

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Tubercular
Non Luetic

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83026

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N Spring ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Sewell

(a) RESIDENCE NO. 415 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	Colored	married

5a If married, widowed, or divorced (or) WIFE of Charles Sewell

6 DATE OF BIRTH (month, day, and year) Sept 25 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37 yrs.	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) mostly for self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Maggie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Matilda Burke

(Address) 415 N. Spring St.

15 JAN 24 1924 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1924, to Jan 22, 1924, that I last saw h[illegible] alive on Jan 22, 1924, and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows: Abscess of Liver

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Enteritis (Colitis?) (duration) yrs. mos. 7 ds.

or Intercurrent)

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Richard Hershinger, M. D.

, 19 (Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Jan 26 1924

20 UNDERTAKER John W Henderson — ADDRESS 1501 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83027

CERTIFICATE OF DEATH.

170 D 83027

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 720 E. 37th St ST., 9 WARD)

2-FULL NAME Irma E. Gischel

(a) RESIDENCE No 720 E. 37th St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Gischel

6 DATE OF BIRTH (month, day, and year) April 19/1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Louis P. Maempel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katherine Benseler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Chas. E. Gischel
(Address) 720 E. 37th ST

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Intercranial Hemorrhage - Pistol wound in Rt. temporal region
(Suicide)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Mental (Melancholia)
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. A. Postey, M. D.
(Coroner.)

Jan 23/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan. 25. 1924
20 UNDERTAKER	ADDRESS
Mrs John W. Leufel & Son	201 W. Fayette St

Spec—12-23-21—E.B.R.S.—400 Eka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83028

CERTIFICATE OF DEATH.

58 D 83028

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2043 E. 32nd St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Washington Baker

(a) Residence No. 2043 E. 32nd St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia E. Baker

6-DATE OF BIRTH (month, day and year) Jan. 25. 1856

7-AGE. 68 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Asst. Postmasters

(b) General nature of Industry, business, or establishment in which employed (or employer). 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, John L. Baker.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Angeline Kellmer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Amelia E. Baker

(Address) 2043 E. 32nd St.

15- JAN 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 22. 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 19 1924 to Jan 22 1924

that I last saw him alive on Jan 21 1924,

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

June 4 1924 (Address) 1107 Lexington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. Jan. 25, 1924

20-UNDERTAKER. Josiah Effler ADDRESS 1600 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Nakryjko

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D 83029

CERTIFICATE OF DEATH.

D 83029

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3127 O'Donnell ST.: 1st WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Nakryjko

(a) RESIDENCE. NO. 3127 O'Donnell ST. 1st WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark N. J.

PARENTS

10 NAME OF FATHER Joseph Nakryjko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Annie Szmilowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Annie Nakryjko

(Address) 3127 O'Donnell St

15 Filed JAN 24 1924 . 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5 1923. to Jan. 22. 1924.

that I last saw him alive on Jan. 22. 1924.

and that death occurred, on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency, following sickness last year with pneumonia, Lobar

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) J. B. Bronakhar, M. D.

(Address) 3037 Odonnell St 1-23-24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Bmn.,	Jan 25" 1924
20 UNDERTAKER	ADDRESS
M. J. Sadowski.	406 S. Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 117 D 83030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital 11 ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Swift

(a) RESIDENCE NO. ..... Fairport Virginia ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fairport Virginia

PARENTS

10 NAME OF FATHER William T. Swift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairport Va.

12 MAIDEN NAME OF MOTHER Linda McNeal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fairport Va.

14 Informant Hosp. Records

(Address)

15 JAN 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1924, to Jan 24, 1924, that I last saw h[illegible] alive on Jan 24, 1924, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

..... (duration) yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

..... (duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date Jan 23-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Dx.

(Signed) Louis H. Wilkinson, M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crem We Va	19
20 UNDERTAKER Harry H Weitzke	ADDRESS 1531 W. Lombard St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83031

CERTIFICATE OF DEATH.

11-00 D 83031

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S. Madeira ST., 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Stanislaus Wankowski

(a) RESIDENCE No. 216 S Madeira ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Wankowski

6 DATE OF BIRTH (month, day, and year) July 25 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	6	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Walenty Wankowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Jozefa Szopczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Eva Wankowski, (Address) 216 S. Madeira St

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-28 1923 to 1-22 1924

that I last saw him alive on 1-22 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

following grippe

(duration) 1 yrs., 1 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F. X. Rupisha M. D.

(Address) 800 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, DATE OF BURIAL Jan 26 1924.

20 UNDERTAKER M. F. Sadowski, ADDRESS 925 S. Ann

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83032

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 83032
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2053 Division St. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Emma Smith

(Residence in Baltimore: No. 2053 Division St. St.; yrs. 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH. about (Month) (Day) 1868 (Year)

7-AGE. 56 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) Wilmington, Md.

PARENTS.

10-NAME OF FATHER. Jas. H. Mason

11-BIRTHPLACE OF FATHER. (State or Country) Md.

12-MAIDEN NAME OF MOTHER. Sarah Green

13-BIRTHPLACE OF MOTHER. (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Smith

(Address) 2053 Division St.

Filed JAN 24 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 20, (Month) (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner's inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 2 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner)

Jan. 23, 1924 (Address) 2807 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, 1/24 1924

20-UNDERTAKER, Samuel Hawsley ADDRESS 1 B Edes St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83033

CERTIFICATE OF DEATH.

D 83033

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Druid Hill Ave ST., 14 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Anderson

(a) RESIDENCE. No. 1525 Druid Hill Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sydonia Anderson

6 DATE OF BIRTH (month, day, and year): Dec 30. 1864

7 AGE: Years 59; Months; Days 23; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Station Porter

(b) General nature of industry, business, or establishment in which employed (or employer): Long Clay R.R. Station

(c) Name of employer: Penn. R. R.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Fanny Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sidonia Anderson

(Address): 1525 Druid Hill Ave

15 JAN 24 1924

ROBERT R. KRAUSER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 23, 1923, that I last saw him alive on Jan 23, 1923 and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) R. Garland Penfield, M. D.

Jan 23 1924 Address 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 1-26 1924

20 UNDERTAKER: George T. Gibson

ADDRESS: 1755 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83034

CERTIFICATE OF DEATH.

X44 D 83034

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.... WARD)

2-FULL NAME Raleigh Koch

(a) RESIDENCE NO. Edgewood ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad

(b) General nature of industry, business, or establishment in which employed (or employer) Engineers

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Mary Zieber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Record
(Address)

15 Filed JAN 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/23/1924

17 I HEREBY CERTIFY, That I attended deceased from 1/8/24, 19..., to 1/23/24, 19..., that I last saw h[illegible]ive on 1/23/24, 19..., and that death occurred, on the date stated above, at 10.50 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas
+ Gall Bladder.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of 1/22/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) K. W. Zieber, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Augustown — DATE OF BURIAL Jan 28 1924

20 UNDERTAKER [illegible] — ADDRESS 164 B'way [illegible] 115 Eutaw St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 83035

~~D 83035~~

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 24 WARD)

2-FULL NAME Joseph Quinn

(a) RESIDENCE NO. 114 Warren Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 24-1922

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
15 weeks.	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Rose Hathaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record
(Address)

15 Filed JAN 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/24

17 I HEREBY CERTIFY, That I attended deceased from 1/9/24, 19..., to 1/24/24, 19...,
that I last saw him alive on 1/24/24, 19...,
and that death occurred, on the date stated above, at 2.20 P.M.
The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) R. W. Kelly, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Est B Forest — DATE OF BURIAL 1-25, 1924

20 UNDERTAKER Mount Burial — ADDRESS Cathedral 115 E North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

Gwyn Saffell

HEALTH DEPARTMENT—CITY OF BALTIMORE

16852 D 83036

CERTIFICATE OF DEATH.

X 31 D 83036

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Gwyn Saffell

(a) RESIDENCE No. Glenburnie St. Md WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred During stay in hospital yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	—	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) to die

(c) Name of employer to

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward E. Saffell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Delphine Kinzer Dead

13 BIRTHPLACE OF MOTHER (city or town) (State or country) California

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 JAN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 23, 1924 that I last saw him alive on Jan 23, 1924 and that death occurred, on the date stated above, at 8 30 P.M.

The CAUSE OF DEATH* was as follows:

Generalized miliary tuberculosis

Tuberculous meningitis

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. H. Wreck, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 1 25 1924

20 UNDERTAKER E & B Hasle — ADDRESS 115 E Vest St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83037

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 83037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Eastlanburg ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Johnson

(a) RESIDENCE. No. 117 Eastlanburg ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24 / 24

7 AGE Years Months Days If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Franck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arthur Johnson
(Address) 117 Eastlanburg

15 [illegible] JAN 24 1924 ROBERT R. KRAUTER, [illegible]
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Jan 24, 1924, that I last saw h in alive on Jan 24, 1924, and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Premature birth
7½ mos fetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm E Butler, M. D.

1/24, 1924 (Address) 1819 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakin Park	1/26/24 19
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 83038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 83038

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Hamburg ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Johnson

(a) RESIDENCE. NO. 117 E Hamburg ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24/24

7 AGE Years Months Days If LESS than 1 day, H hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arthur Johnson
(Address) 117 E Hamburg

15 Filed JAN 24 1924 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Jan 24, 1924, that I last saw him alive on Jan 24, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature birth
about 7 months
Jaun.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. McClintock, M. D.

1/24, 1924 (Address) 13.9 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 1/27/1924

20 UNDERTAKER: J. J. Fahey & Sons. — ADDRESS: 1318 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83039

167214

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

X 4 D 83039

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL** 7

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME James Burns

(a) RESIDENCE NO. 2137 3d St. N. W. Washington D. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Market Master

(b) General nature of Industry, business, or establishment in which employed (or employer) 4 886

(c) Name of employer 4

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Mary Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

AN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Jan 23, 1924, that I last saw h[illegible] alive on Jan 23, 1924, and that death occurred, on the date stated above, at 10:10 p.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma Bladder

(duration) 2 yrs. 8 mos. over ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 3rd 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interred Loudon Park

DATE OF BURIAL 1/25/24

20 UNDERTAKER George J. Smith

ADDRESS Washington D.C.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83040

CERTIFICATE OF DEATH.

101

D 83040

1-PLACE OF DEATH — Wincentas Maleisko — REGISTERED NO.

CITY OF BALTIMORE: (No. 800 Ensor ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Malerki

(a) RESIDENCE. No. 800 Ensor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Notknown

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Notknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Notknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant A. Yenkunas
(Address) 800 Ensor Street

15 [illegible] 1924 Robert P. Harrison, Registrar

JAN 24 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 22. 1924. to Jan 23. 1924.
that I last saw him alive on Jan 23. 1924
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Tabes Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.
1-23. 1924 (Address) 120 Leisguth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan. 25. 1924

20 UNDERTAKER — ADDRESS

John Grebliauckas J.G. 425 S Paca St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83041

CERTIFICATE OF DEATH.

83041

REGISTERED NO. 16 74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1918 Riggs ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Schminger

(a) RESIDENCE. NO. 1918 Riggs ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pauline E. Schminger

6 DATE OF BIRTH (month, day, and year) July 17th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired fireman

(b) General nature of industry, business, or establishment in which employed (or employer) City Fire Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Conrad Schminger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant E. J. Gamble
(Address) 1918 W. Riggs Ave

15 Filed 19 Robert F. Harrison, Registrar

JAN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1923, to Jan 21, 1924

that I last saw him alive on Jan 21, 1924

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

1-22 1924 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL 1-26 1924

20 UNDERTAKER H. C. Bruning Son

ADDRESS 317 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 ✓

D 83042

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 9 WARD)

2-FULL NAME John Blank

(a) RESIDENCE NO. Helmere, Annapolis ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of Blanch Blank

6 DATE OF BIRTH (month, day, and year): May 17 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Waets Md

PARENTS

10 NAME OF FATHER: Michael Blank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mrt Kuntz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Blanche Blank
(Address): Helmere Md

15 Filed ..... 19 .....
Robert F. Harrison,
Registrar
~~Burial Permit Clerk.~~

JAN 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Jan 24, 1924.

That I last saw h alive on Jan. 24, 1924

and that death occurred, on the date stated above, at 2.40 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Carcinoma Sigmoid

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Peritoneal Sepsis

Intestinal Sepsis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Helmere, Annapolis

Did an operation precede death? Yes Date of Jan 15, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Operation Physical Evidence

(Signed) Geo. B. Dyberk, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	Jan 24 19 24

20 UNDERTAKER: Ralph Johnson Jr

ADDRESS: Annapolis Md

Spec.—1-10-21—M&T—1500 Blks.

D 83043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83043

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Bennett Place ST., 18 WARD)

2-FULL NAME Mary L. Degen,

(a) RESIDENCE No. 1023 Bennett Place ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Degen,

6 DATE OF BIRTH (month, day, and year) Dec. 18. ~~1924~~ 1854

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	69	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

600

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Valentine Sultan,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorthea Kepler,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Valentine Degen.
(Address) 1023 Bennett Place

15 JAN 24 1924 Filed ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24. 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany 20. 1924, to Jany 24. 1924.

that I last saw her alive on Jany 24. 1924.

and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Frank E. Wagner M. D.

Jan. 24. (Address) 2006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Jan. 28. 1924

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 83044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83044

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 W.Franklin St. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie V.Curry,

(a) RESIDENCE NO. 1215 W.Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M.Sterling Curry,

6 DATE OF BIRTH (month, day, and year) April 9.1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	40	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.Md.

PARENTS

10 NAME OF FATHER John W,Burns,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore CO.Md.

12 MAIDEN NAME OF MOTHER Eliza A.Cooper,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.Md.

14 Informant M. S. Curry (Address) 1216 W Franklin St

15 Filed Robert P. Harrison, Registrar

AN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.24.1924

17 I HEREBY CERTIFY, That I attended deceased from June 1923 to Jany 24th 1924.

that I last saw her alive on Jany 24th 1924

and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma of Sigmoid -

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Ulcer of Sigmoid & Carcinoma (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1923.

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Howard Kelly M. D.

1/24. 1924 (Address) 76 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Jan. 26 1924

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83045

88

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 Penrose ave. WARD 20)

2-FULL NAME Mary C. C. Cannen

(a) RESIDENCE. No. 2033 Penrose ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced (or) WIFE of Lavina Cannen

6 DATE OF BIRTH (month, day, and year) June 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Jacob Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria Germany

12 MAIDEN NAME OF MOTHER Mary Bankman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lebanon Pa

14 Informant (Address) Anna E. Dunphy 2033 Penrose Ave

15 Filed JAN 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 14th 1924 to January 24th 1924 that I last saw h alive on Jan 24th 1924 and that death occurred, on the date stated above, at — 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of the Lungs (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) William Schulman M. D.

1/23 1924 (Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/25/24

20 UNDERTAKER George A Farley Fulton ADDRESS Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83046

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. ST. 20 WARD)

2-FULL NAME Mrs. Anna Mitchell

(a) RESIDENCE No. 1952 W. Fayette ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Guy K. Mitchell

6 DATE OF BIRTH (month, day, and year) ~~December~~ November 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Emile Wissler

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Penna

12 MAIDEN NAME OF MOTHER Babetta Duentzler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bavaria

14 Informant Guy K. Mitchell
(Address) 1952 W. Fayette St.

15 Filed ....., 19 .....

Robert P. Harrison,
Registrar

JAN 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-21-, 1924, to 1-23, 1924.

that I last saw her alive on 1-23, 1924

and that death occurred, on the date stated above, at 7 ½ P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Acute diffuse neuritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Leo Tonyes M. D.

, 19 (Address) 1952 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 26 1924

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

GOD 83047

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 220 Richmond St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Hanrathy

(a) Residence No. 220 Richmond St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 53 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 53 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne Kieran

6-DATE OF BIRTH (month, day and year): Mar. 22, 1843

7-AGE: 80 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Patrick Hanrathy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary McConnell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-(Informant): Miss May Hanrathy

(Address): 220 Richmond Street

15-Filed JAN 24 1924 Robert P. Harries... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/23/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to Jan. 23 19 24

that I last saw h[illegible] alive on Jan 23 19 24

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis general
with hypocardiac insufficiency

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Embolism

Suddenly (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. F. Means M. D.

1/24/24 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross Cemetery	1/26 1924
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83048

CERTIFICATE OF DEATH.

122 D 83048

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 Bernard ST., 12 WARD)

2-FULL NAME Daniel B Shipley

(a) RESIDENCE NO. 2900 Bernard ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Shipley

6 DATE OF BIRTH (month, day, and year) Dec 20 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER William Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alicia Alberta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Mary A Shipley
(Address) 2900 Bernard St

15 Robert L. Harrison, Registrar

JAN 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to June 23, 1924, that I last saw h alive on June 23, 1924, and that death occurred, on the date stated above, at 950 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. Five Days mos. ds.

CONTRIBUTORY (secondary) Arteriosclerosis

(duration) yrs. Years mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1924 (Address) 1126 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden DATE OF BURIAL Jan 25 1924

20 UNDERTAKER [illegible] & SON, ADDRESS 3617 CHESTNUT AVE

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Alcoholic

Cor.—1-12-23—M&T—100 Bks.

D 83049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D 83049

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 28 WARD)

2-FULL NAME Mary Rosa Garibaldi

(a) RESIDENCE NO 4702 Liberty H'ts Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 5/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Antini Garibaldi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosaria Tanbuo

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Antoni Garibaldi
(Address) 4702 Lib. Ht's Ave

15 Filed JAN 24 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows

Diabetic Coma

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitis (duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. S. H. Waller, M. D.
(Coroner)

Jan 23/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 1-26 192 4

20 UNDERTAKER David Easton

ADDRESS 916 Pac ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83050

CERTIFICATE OF DEATH.

100-001 D 83050

1-PLACE OF DEATH

City of BALTIMORE: (No.) 328 N. Stricker St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Brown

(a) Residence No. 328 N. Stricker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Beckett Brown

6-DATE OF BIRTH (month, day and year) Feb 18 74

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self Employed

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Annapolis Md

PARENTS.

10-NAME OF FATHER, Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER, don't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) don't know

14- (Informant) David Easton

(Address) 916 Penna

15- (Filed) JAN 24 1924, 192.., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923 to Jan 23, 1924

that I last saw him alive on Jan 23, 1924

and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M.D.

(Address) 662 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Dist Cadem ... | DATE OF BURIAL, 1-26, 1924

20-UNDERTAKER, David Easton | ADDRESS 916 Penna

Burial Permit Clerk.

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

D 83051

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1524 Baker St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Blake

(a) Residence No. 1524 Baker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Blake

6-DATE OF BIRTH (month, day and year): Apl 25 1895

7-AGE: 28 yrs. 8 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Work 037

(b) General nature of industry, business, or establishment in which employed (or employer): Gen'l Work

(c) Name of employer: At Home

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

11- (Informant) Samuel Blake

(Address) 1524 Baker St

15- [illegible] 10 Robert P. Harrison, Registrar.

JAN 24 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jany 23-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1923, to Jany 23, 1924, that I last saw her alive on January 20th, 1924, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis (Duration) — yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis & Cardiac Weakness (Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward Eichacker M. D

Jany 24, 1924 (Address) 1339 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1-26 1924
Mt Auburn	
20-UNDERTAKER, David Eaton	ADDRESS 966 Cam

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important—See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No history

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS shall be required to fill promptly be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Lippi)

D 83052

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

2-FULL NAME Jr. Lippi

(a) RESIDENCE NO. St. Josephs Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years: 52. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Orderly 086

(b) General nature of industry, business, or establishment in which employed (or employer): Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospital Records

(Address)

15 Filed JAN 24 1924, 19 Robert P. Harrison, Registrar

Ward Pruett Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924 to Jan 23, 1924

that I last saw him alive on Jan 23, 1924

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Schemm M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Trinity Cem. DATE OF BURIAL: 1/25/24

20 UNDERTAKER: Geo. J. Roth ADDRESS: 1730 Hanfd

Spec.—1-10-21—M&T—1900 Bks.

D 83053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1902 D 83053

159

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 N. Chapel ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Leopold Sadler

(a) RESIDENCE NO. 1608 N. Chapel ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of. —

6 DATE OF BIRTH (month, day, and year) Jan 14 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER J. Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Nolan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Julius Sadler.
(Address) 1608 N. Chapel St

15 19 Robert P. Harrison, Registrar

JAN 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-14, 1924, to 1-24, 1924, that I last saw him alive on 1-24, 1924, and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Open Foramen Ovale

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Atelectasis

..... (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical - gross at birth

(Signed) Edward Miller, M. D.

, 19 (Address) 1506 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Jan 25 1924
20 UNDERTAKER	ADDRESS
George J. Leith	35 Hanover

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83054

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Park Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Armistead Wooldridge

(a) RESIDENCE NO. 1709 Park Ave ST., WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs. 7 mos. 2 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Jelke Wooldridge

6 DATE OF BIRTH (month, day, and year) June 21 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Chesterfield Courthouse Virginia

PARENTS

10 NAME OF FATHER Joseph Wooldridge

11 BIRTHPLACE OF FATHER (city or town) Chesterfield (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Goode

13 BIRTHPLACE OF MOTHER (city or town) Camden (State or country) South Carolina.

14 Informant Mrs Ina J. Wooldridge (wife) (Address) 1709 Park Ave.

15 Filed ..., 19 ... Robert P. Harrison, Registrar

JAN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 23 1924

17

I HEREBY CERTIFY, That I attended deceased from ..., 1909, to Jany 22, 1924, that I last saw him alive on Jany 22, 1924 and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, increasing insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardio-vascular disease with mental & physical paresis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E. H. Van Ness, M. D.

1.23, 1924 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan 25 1924

20 UNDERTAKER H. P. MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 83055 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1714 Bolton St. 14 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Julia Lee Clark

(Residence in Baltimore: No. 1714 Bolton St.; 76 yrs., ...mos., ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. About 1848
(Month) (Day) (Year)

7-AGE. About 76 yrs. ? mos. ? ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Michael L. Clark

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Anne Johnston

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Anny Everist (Friend)

(Address) 1714 Bolton St

15- JAN 24 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 24, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(Duration) ....yrs. 4 mos.....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ....yrs. 2 mos.....ds.

(Signed) C. E. Heemsoth M. D.
(Coroner)

Jan. 24 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Washington D.C. DATE OF BURIAL. Jan 26th 1924

20-UNDERTAKER. J. H. BOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shown state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83056

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (N.) 5 East Wylie St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise E. Schaefer

(a) Residence No. 5 E. Wylie St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas. H. Schaefer

6-DATE OF BIRTH (month, day and year) Dec-10-1868

7-AGE, 55 yrs. 1 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Lange

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-

(Informant) E. H. Schaefer

(Address) 5 E. Wylie St.

JAN 24 1924

Albert T. Morris, 192

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 7, 1923, to Jan 23, 1924

that I last saw h[illegible] alive on Jan 23, 1924

and that death occurred, on the date stated above, at 12.30 [illegible]

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation Heart ?

(Duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Pneumonia Colitis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John D. Gilbert, M. D.

, 19 (Address) 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery — DATE OF BURIAL, Jan 26, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 501 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83057

CERTIFICATE OF DEATH.

89 D 83057

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2117 E. Preston ST., 8 WARD)

2-FULL NAME Christian E. Diffenbaugh

(a) RESIDENCE NO. 2117 E. Preston ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Laurine E Diffenbaugh

6 DATE OF BIRTH (month, day, and year) Dec. 24. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tally Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Christopher Diffenbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Catherine Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Laurine E. Diffenbaugh

(Address) 2117 E. Preston St.

15 JAN 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20. 1924 to Jan 24 1924.

that I last saw him alive on Jan 24 1924,

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Congestion of Respiratory Paralysis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. E. Reuter, M. D.

Jan 24 1924 (Address) 201 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan. 26 1924

20 UNDERTAKER: Henry Storck & Son — ADDRESS: 1901 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Angina Pectoris

Spec.—1-10-21—M&T—1500 Bks.

D 83058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D 83058

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Lowry ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Stein

(a) RESIDENCE NO. 210 S6 Lowry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	2.	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Michael Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Edith Spellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Michael Stein

(Address) 210 S Lowry St

15 JAN 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23-1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1924, to Jany 23, 1924

that I last saw ~~him~~ alive on Jan 23, 1924

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ' yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Grip

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Shepherd Brown, M. D.

, 19 (Address) Lying Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	Jan 26 19
20 UNDERTAKER John Stields	ADDRESS 210 N Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83059

Registered No.....

1-PLACE OF DEATH 308 South Chester St. 2 4

City of BALTIMORE: (No..... St..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward McDonough

(a) Residence No. 308 South Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Nora McDonough

6-DATE OF BIRTH (month, day and year) March 15 1867

7-AGE. 56 yrs. 10 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Water Dept.

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick McDonough

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) John McDonough

(Address) 308 So Chester St

15- FILED JAN 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-24-24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1924, to Jan 24, 1924, that I last saw h[illegible] alive on Jan 23, 1924, and that death occurred, on the date stated above, at 10.20 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia Croupous

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D

, 1924 (Address) 502 E Pratt St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Jan 28, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83060

100-001 D 83060

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Riggs Ave ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanna Lapes

(a) RESIDENCE. NO. 1423 Riggs Ave ST. ..... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 19 1873

7 AGE: Years 50 Months 1 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore MD

PARENTS

10 NAME OF FATHER Sam Lapes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balti MD

12 MAIDEN NAME OF MOTHER Rose Lapes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balti MD

14 Informant Jake Lewis

(Address) 1439 E Baltimore

15 JAN 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1924 to Jan 24 1924

that I last saw h[illegible] alive on Jan 24 1924

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilation

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Yes Street

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm E Ziegler M. D.

1/30/ 1924 (Address) 2401 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Andrew mount Cemetery — DATE OF BURIAL: 1/25 1924

20 UNDERTAKER: Jake Lewis — ADDRESS: 1439 E Balti

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83061

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

City of BALTIMORE: (No. 4120 E: Lombard St St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Riley

(a) Residence No. 4120 E: Lombard st St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas A: Riley

6-DATE OF BIRTH (month, day and year) Mar 30 1892

7-AGE.			If LESS than 1 day.
31 yrs.	9 mos.	22 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Clay

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Lena Hartman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Chas A: Riley

(Address) 4120 E: Lombard St

15- JAN 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/22/24.

17- I HEREBY CERTIFY, That I attended deceased from Jan 19, 1924 to Jan 22, 1924, that I last saw h.. alive on Jan 22 1924 and that death occurred, on the date stated above, at 9.25 a m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Auto)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Miscarriage

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of Jan 19 24

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Dean M. D.

1/24, 1924 (Address) 390 Garrison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn Cem	Jan 25 1924
20-UNDERTAKER. John Merrick	ADDRESS. 2008 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83062

CERTIFICATE OF DEATH.

D 83062

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Rotert St. 14 WARD)

2-FULL NAME Ignatius Butler

(a) RESIDENCE NO. 518 Rotert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Butler

6 DATE OF BIRTH (month, day, and year): May 1865

7 AGE: Years 58 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chas Co. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chas Co Md

12 MAIDEN NAME OF MOTHER: Caroline Smoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chas Co Md

14 Informant: Estella Butler

(Address): 518 Rotert St

15 JAN 25 1924 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20 1924 to Jan. 23 1924

that I last saw him alive on Jan. 23 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs.

(Signed) W. F. Carr, M. D.

1924 (Address) 515 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 26 1924

20 UNDERTAKER: Hamme & Wright — ADDRESS: 1364 W Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 83063

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 William ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah L. Davis

(a) RESIDENCE NO. 1404 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John G. Davis

6 DATE OF BIRTH (month, day, and year) Jan 11, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	68	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home gd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Joshua A. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Grace T. Davis

(Address) 1404 William St

15 Filed JAN 25 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1924

17

I HEREBY CERTIFY, That I attended deceased from 8-10-22, 19.., to 1.22.24, 19..,

that I last saw h.. alive on 1-22-24, 19..,

and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Brammary

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip B. Fowler, M. D.

1.23.24, 19 (Address) 1032 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Jan 25 24

20 UNDERTAKER Wm J. Tickner & Sons ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.H.S.—400 Blks.

D 83064

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83064

CERTIFICATE OF DEATH.

129

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Hubbard

(a) Residence No. Bay View Hospital St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hubbard

6-DATE OF BIRTH (month, day and year) Mar 15. 1855

7-AGE. 68 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Street 186

(b) General nature of Industry, business, or establishment in which employed (or employer). Cleaner

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Sam Hubbard

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Balto., Md.

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town). ? (State or Country).

14- (Informant) Municipal Hospital Record

(Address)

15- Filed JAN 25 1924 ROBERT R. KRAUTER, Clerk Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 21 19 24 to January 23 19 24

that I last saw h. im alive on January 23 19 24

and that death occurred, on the date stated above, at 11:2 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Chronic Nephritis

Right Hemiplegia (Residual) — 3 yrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) Claude B. Hance M. D.

1-23 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Jan 26 1924

20-UNDERTAKER. W. J. Flickner & Sons ADDRESS North & Pa

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 8 74 001 D 83065

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 N. Washington St., ... Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Lucretia R. Phipps

(a) Residence No. 1026 N. Washington St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. P. Phipps

6-DATE OF BIRTH (month, day and year) July 29/47

7-AGE. 76 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto

PARENTS.

10-NAME OF FATHER. John Sydnings

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Md

14- (Informant) Randolph R. Phipps

(Address) 1026 N. Washington

15- Filed JAN 25 1924 ROBT. R. KRAUTER Registrar. Deputy Registrar Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 23/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1923 to Jan 23 1924 that I last saw h[illegible] alive on Jan 22 1924 and that death occurred, on the date stated above, at 3 52 A. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) ..... yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. 2 mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas B Lucian M. D.

1/23 1924 (Address) 718 N Pat Pk Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cem — DATE OF BURIAL, 1/26 1924

20-UNDERTAKER. Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83066

CERTIFICATE OF DEATH.

5 46 D 83066

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Turner

(a) Residence No. 513 N. Central Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. William Monroe

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15-

Filed ... 192 ... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 22, 1924 to January 23, 1924

that I last saw h.. alive on January 23, 1924

and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary with General Concomitants

(Duration) yrs. 1 mos. (Estimated)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Bruce M. D

1-24-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laural Cem DATE OF BURIAL. Jan 25 1924

20-UNDERTAKER Mrs R A Elliott ADDRESS 1725 Eastland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21 M&T. 1500 Blks.

16900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83067

CERTIFICATE OF DEATH.

31

D 83067

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo W. Grays

(a) RESIDENCE NO. 2538 Mace St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 24 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	1	—	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leo Grays

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sadie Robin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 JAN 25 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1928, to Jan 23, 1924 that I last saw her alive on Jan 23, 1924 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous broncho-pneumonia.

(duration) yrs. 1 mos. ? ds.

CONTRIBUTORY (Secondary) General miliary tbc. with meningitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray - Lumbar puncture

(Signed) A. A. Reed M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 25-24
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

127-001 D 83068

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1170 McElderry ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isiah Giles

(a) RESIDENCE. No. 1170 McElderry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melvina Giles

6 DATE OF BIRTH (month, day, and year) Dec 10, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	one	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in Cemetery

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Laurel Cemetery Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Melvina Giles (Address) 1170 McElderry St

15 Date Received JAN 25 1924 Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924 to Jan 23, 1924

that I last saw him alive on Jan 22, 1924

and that death occurred, on the date stated above, at 9.36 P.M.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver

(duration) - yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative.

(Signed) F. E. Linthicum, M. D.

Jan 25-1924 (Address) 1108 North Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 27 1924
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholic

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83069

CERTIFICATE OF DEATH

D 83069

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Laura Pick

(a) RESIDENCE NO. Harrisonville Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Feb 5 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Rudolph Pick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Blaufly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... Hospital Records
(Address)

15 Filed JAN 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-24, 1924, to 1-24, 1924, that I last saw her alive on 1-24, 1924, and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) ..... M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery | DATE OF BURIAL Jan 27, 1924

20 UNDERTAKER Wm. C. Weber | ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83070

D 83070

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH General German Aged People's Home

CITY OF BALTIMORE: (No. N E Cor Balto Hayson ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Foard

(a) RESIDENCE. NO. N E Cor Baltimore Payson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Harrison Foard

6 DATE OF BIRTH (month, day, and year) Feb. 19. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None / Retired

(b) General nature of industry, business, or establishment in which employed (or employer) School Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George Rea

11 BIRTHPLACE OF FATHER (city or town) Harford County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER A Catherine Huffenbach

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County
(State or country) Maryland

14 Informant Records of German Aged Home
(Address) N E Cor Baltimore & Payson Sts

15 Filed JAN 25 1924 . 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1924, to Jan 24 . 1924.
that I last saw her alive on Jan 23 . 1924.
and that death occurred, on the date stated above, at 3a m.
The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Haeff M. D.

(Address) 1843 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 26 19 24
20 UNDERTAKER Joseph L. Cook	ADDRESS 1003 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83071 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 123 D 83071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2111 Wilkins Ave St. 20 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Caroline Zauser

(a) Residence No. 2111 Wilkins Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 16, 1847

7-AGE, 79 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, H. Frederick Fricke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, K. Rosenberger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-INFORMANT, E. Elizabeth Zauser

(Address) 2111 Wilkins Ave

15-JAN 25 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 23/24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1924, to Jan 23, 1924, that I last saw h~~e~~r alive on Jan 23, 1924, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Lungs
Cerebral Hemorrhage Independent
Hypostatic Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Mitch M. D.

1/25/, 19 (Address) 2151 Wilkins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Jan 26, 1924

20-UNDERTAKER, George J. Smith — ADDRESS 153 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83072 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
D 83072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 S. Dueshan St., V Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kofuck

(a) Residence No. 427 S Dueshan St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of c

6-DATE OF BIRTH (month, day and year) Jan 13-23.

7-AGE. 1 yrs. mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Nov.
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Paul Kofuck.

11-BIRTHPLACE OF FATHER (City or Town) (State or Country) Poland.

12-MAIDEN NAME OF MOTHER M. Kacinska

13-BIRTHPLACE OF MOTHER (City or Town) (State or Country) Balto Pa.

14- (Informant) Mrs Paul Kofuck (Address) 427 S Dueshan st

15- Filed ..... 192.. Burial Permit Clerk. ROBERT R. KRAUTER, JAN 25 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/24/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 22, 19 24, to Jan 24, 19 24.

that I last saw h.. alive on Jan 23, 19 24.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Klamund R. Gerhardt, M. D.

, 19 (Address) 3320 Pittsman

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Stanislaus Cem	Jan 26, 19 24
20-UNDERTAKER.	ADDRESS
F. X. Ozarowski	1938 Eastern ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83073

CERTIFICATE OF DEATH.

91-002 D 83073

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 42 N. Fulton St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. McCann

(a) Residence No. 42 N. Fulton ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna McCann

6-DATE OF BIRTH (month, day and year) Feb 10, 1851

7-AGE. 72 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Richmond Va

PARENTS.

10-NAME OF FATHER, Maurice McCann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Anna McCann

(Address) 42 N. Fulton ave

15- JAN 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1924 to Jan. 22, 1924 that I last saw him alive on Jan. 22, 1924 and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (5 yrs.)

Gangrene of right foot

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acidosis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw V. Coolahan, M. D.

1/24, 1924 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem.	Jan 26, 1924
20-UNDERTAKER.	ADDRESS
F. A. Frauenson	733 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83074

CERTIFICATE OF DEATH.

D 83074

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 S. Woodyear ST., 19 WARD)

2-FULL NAME Thelma Bertha Winters

(a) RESIDENCE NO. 333 S. Woodyear. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 20-1904.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Button hole maker

(b) General nature of industry, business, or establishment in which employed (or employer) clothing

(c) Name of employer Grieff & Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER August Winters Jr

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie M. Clopper

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant August Winters Jr.
(Address) 333 S. Woodyear St.

15 JAN 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24 1924.

17 I HEREBY CERTIFY, That I attended deceased from Sept - 27, 1923, to January 24, 1924, that I last saw her alive on January 23 - 1924, and that death occurred, on the date stated above, at 3:05 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) — yrs. 9 mos. 24 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum.

(Signed) Chester Rolands, M. D.

1-24, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	1-28-1924
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun Hopkins 27

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83075

CERTIFICATE OF DEATH.

118-002 D 83075

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 E Northam ST. 8 WARD)

2-FULL NAME Gloria L. Clark.

(a) RESIDENCE No. 2208 E North ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 20/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER F. Louis Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER M. Emma Roth

13 BIRTHPLACE OF MOTHER (city or town) City. (State or country)

14 Informant F. Louis Clark.

(Address) 2208 E North ave

15 JAN 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1924, to Jan. 24, 1924, that I last saw her alive on Jan. 24, 1924, and that death occurred, on the date stated above, at 1 P.M. m.

The CAUSE OF DEATH* was as follows:

Intussusception (acute)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigani, M. D.

, 19 (Address) 2951 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 1/26 1924

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1800 Bks.

D 83076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 83076

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp ST., 70 WARD)

2-FULL NAME Carl Daum

(a) RESIDENCE NO. 360 Culver St City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Daum

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass-blower 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marie Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carl Daum

(Address) 360 Culver St. City

JAN 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1924, to Jan. 23, 1924

that I last saw him alive on Jan. 23, 1924

and that death occurred, on the date stated above, at 2 05 P. m.

The CAUSE OF DEATH* was as follows:

Acute hemorrhagic nephritis - Terminal uraemia and pulmonary oedema. 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ward

Did an operation precede death? No Date of

Was there an autopsy? Partial.

What test confirmed diagnosis? autopsy.

(Signed) M. Alexander Mabey M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Jan. 26, 1924.
20 UNDERTAKER	ADDRESS
Chas. W. Dill.	3109 Frederick Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause undetermined

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Hill) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83077

D 83077

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N. Schroeder St. ST.: 18 WARD)

2-FULL NAME Eliza A. Hill (Hill)

(a) RESIDENCE. NO. 528 N. Schroeder ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hill

6 DATE OF BIRTH (month, day, and year) Dec 13 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Va

PARENTS

10 NAME OF FATHER Benjamin A. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Eliza Monroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Leesburg Va

14 Informant Leesburg Va

(Address) W. 14th St Baltimore

JAN 25 1924. 19 Robert P. Morrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Jan 24, 1924, that I last saw h[illegible] alive on Jan 24, 1924, and that death occurred, on the date stated above, at 2.40 P m. The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(curation) ... yrs. mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Love, M. D.

. 19 (Address) 836 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Jan 26th 1924
20 UNDERTAKER	ADDRESS
William W. Shives	1018 E Monument Ave

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 83078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83078

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Baker

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1866

7-AGE. 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): 02

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14-(Informant) Municipal Hospital Record

(Address) JOHNS HOPKINS HOSPITAL

15-[illegible] 192 Robert P. Harrison, Registrar.

JAN 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 5, 1924 to January 22 1924, that I last saw him alive on January 22 1924, and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation - 3 mins

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured left hip (over)

(Duration) yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) Wm. J. Fulton, M. D

1-23-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, 19....

20-UNDERTAKER: Commissioner Health.

ADDRESS JAN 25 1924

PRT. WM. K. WOODALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Accidental fall on side walk.

Cor.—1-12-23—M&T—100 Bks.

D 83079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1D 83079

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Bay View Hospital ST., V V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Fagan

(a) RESIDENCE No. Friendly Inn — Shore St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	About 50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Police Dept. Eastern Dist. — JOHNS (Address)

15 ....., 192 Robert P. Harrison, Registrar

JAN 25 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ptomaine Poisoning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Eating decayed fruit

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D. (Coroner.)

Jan 23rd, 1924 (Address) Curbis Bay, Md.

*State the Disease Causing Death, or if Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	JAN 25 1924, 192
20 UNDERTAKER Commissioner Health.	ADDRESS

THE MORGUE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 83080

3

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Quinlin

(a) Residence No. 103 S. Bond St. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1857

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Quilen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

11- (Informant) Municipal Hospital Record

(Address) JOHNS

13- Registrar. Robert P. Harrison,

JAN 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 22 19 23 to January 22 19 24

that I last saw him alive on January 22 19 24

and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Auricular Fibrillation

Myocardial degeneration

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) Claude G. Wilson, M. D

1-23-, 19 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19....
HOPKINS HOSPITAL	
20-UNDERTAKER,	ADDRESS
Commissioner Health.	JAN 25 1924

Wm. E. WOODALL

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Trostley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83081

90 3b D 83081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 327 Whitridge ST., 4th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Short

(a) RESIDENCE No. 327 Whitridge ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Thomas Short

6 DATE OF BIRTH (month, day, and year): — 1855

7 AGE: about 69 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Warwick

(Address) 327 Whitridge

15 Filed JAN 25 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Disease of
heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Morrison M. D.
(Coroner.)

Jan 24, 1924 (Address) 502 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden — DATE OF BURIAL: 1/26 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

CAUSE should be stated EXACTLY. PHYSICIAN'S abbreviations should be avoided, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83082

HEALTH DEPARTMENT,—CITY OF BALTIMORE

D 83082

CERTIFICATE OF DEATH.

25 129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 437 Frederick St., 23 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Berlin

(a) Residence No. 437 Frederick St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-If Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Louise Berlin

6-DATE OF BIRTH (month, day and year) Aug- 861

7-AGE. 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer .....

9-BIRTHPLACE (city or town) .....
(State or Country) Germany

PARENTS.

10-NAME OF FATHER Martin Berlin

11-BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Germany

12-MAIDEN NAME OF MOTHER Louise Kirk

13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Germany

14-INFORMANT Leo W. Berlin
(Address) 3034 Barclay

15- Filed JAN 5 1924 19.. Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 25-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 16 1924 to Jan 25 1924 that I last saw h. alive on Jan 23 1924 and that death occurred, on the date stated above, at 6a m. The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. V. Brode M. D

19 (Address) Brooklyn Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	1/28 19 24
20-UNDERTAKER. Wm Cook	ADDRESS 501 E Monu

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Error-833 Fulton

D 83083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83083

CERTIFICATE OF DEATH.

+90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1929 Pennsylvania ave St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Isaac Shriver

(a) Residence No. 1929 Pennsylvania ave St., Ward. Harney Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Nevina Shriver

6-DATE OF BIRTH (month, day and year) Sept 13th 1848

7-AGE. 75 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pa

PARENTS.

10-NAME OF FATHER Christian Shriver

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Jane Fischer

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) Simpson E. Shriver

(Address) 1929 Pennsylvania ave

15- Filed ..... 19..... Robert P. Harrison, Registrar.

JAN 25 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 24th 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 24th 1924 to Jan 24th 1924 that I last saw h[illegible] alive on Jan 24th 1924 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Hart disease probably Myocardia

(Duration) nna yrs. nna mos. nna ds.

CONTRIBUTORY (Secondary) Nos Senile 22 1

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Tilman Evans M. D.

Jan 25, 1924 (Address) 8733 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Harney Md	1/26
20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Cor.—1-12-23—M&T—100 Bks.

D 83084

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-007 ✓ D 83084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Roycroft

(a) RESIDENCE NO. 728 S. Curley St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Roycroft

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
43 yrs.	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gas Pipe Inspector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gas & El. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jos. H. Roycroft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Blum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Chas. A. Roycroft
(Address) 531 N. Washington St.

15 JAN 25 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
(accidental)
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fell from motorcycle
(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)
Jan. 24 1924 (Address) 28 W. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. — DATE OF BURIAL Jan. 26 1924

20 UNDERTAKER Tully & Zile — ADDRESS 403 S. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83085

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D 83085

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3112 Dillon ST.: 18 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Hawkins

(a) RESIDENCE. No. 3112 Dillon ST., 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael

6 DATE OF BIRTH (month, day, and year) March 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Patrick McDermid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Carney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Michael Hawkins

(Address) 3112 Dillon St

15 Filed JAN 25 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1924 to Jan. 20, 1924, that I last saw her alive on Jan. 20, 1924, and that death occurred, on the date stated above, at 9:50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (apoplexy) due to arterio-sclerosis with systolic 250 and 140 diastolic blood pressure (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bromsbar, M. D.

1-22 1924 (Address) 3037 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Jan 26 1924

20 UNDERTAKER Lilly and Zeile

ADDRESS 403 S. Wolfe St

Spec.—1-10-21 M&T 1500 Bks.

~~D 83086~~ 18704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83086

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL. 76

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Wicks

(a) RESIDENCE NO. 309 S. 13th St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Catherine Wicks

6 DATE OF BIRTH (month, day, and year) Feb 24 1886

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	10	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) —"— 913

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Nicholas Wicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed Jan 27 1924 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Jan 24, 1924.

that I last saw him alive on Jan 24, 1924,

and that death occurred, on the date stated above, at 1.30 4 m.

The CAUSE OF DEATH* was as follows:

Cancer - melanosis

to brain

T

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

Bilateral

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 5-24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Julian D. Hart M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem. DATE OF BURIAL Jan 27 1924

20 UNDERTAKER Lilly and Zile ADDRESS 403 [redacted]

JAN 27 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

First organ involved
the Lung

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83087

CERTIFICATE OF DEATH.

24 129 D 83087

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Williams ST.: 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Morgan Sr.

(a) RESIDENCE. NO. 831 Williams ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Nat Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nat Known.

12 MAIDEN NAME OF MOTHER Nat Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nat Known.

14 Informant Thomas H Morgan Jr.

(Address) 831 Williams

15 Filed JAN 25 1924 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Jan 24, 1924, that I last saw him alive on Jan 24, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio vascular disease (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab exam

(Signed) Wm. E. Stafford, M. D.

1/26, 1924 (Address) 1319 Lights St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Windy Hill Talbot Co. Md. DATE OF BURIAL: 1/26/1924

20 UNDERTAKER: E. D. Fanning Inc-1928 E Fayette St

ADDRESS

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83088

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83088

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 N. Patterson Park ave. WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan R. Knott.

(a) RESIDENCE No. 1200 N. Patterson Park ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late William J. Knott.

6 DATE OF BIRTH (month, day, and year): July 4 1853.

7 AGE: Years 70 Months Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot County Md

PARENTS

10 NAME OF FATHER: William Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot County.

12 MAIDEN NAME OF MOTHER: Mary. Price.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Frank Marschi

(Address): 1200 N. Patterson Park ave.

JAN 25 1924

[illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Jan 24, 1924.

that I last saw h. W. alive on Jan 23, 1924,

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis + Aortic regurgitation

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory tests

(Signed) Albert J. Singleton M. D.

1924 (Address) 613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery.

DATE OF BURIAL: Jan. 26 1924

20 UNDERTAKER: Geo. J. Ruth.

ADDRESS: 1735 Harford ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83089

1-PLACE OF DEATH

REGISTERED NO. 4 + 90

CITY OF BALTIMORE: (No. Univ. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Kreutzer

(a) RESIDENCE No. Linden Terrace ST. Pikesville Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Kreutzer

6 DATE OF BIRTH (month, day, and year) April 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Chas Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry F. Kreutzer (Address) 1802 Poplar Grove St

15 [illegible] 19 [illegible] Registrar

JAN 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/19/23, 19 ..., to 1/24/24, 19 ..., that I last saw h[illegible] alive on 1/24/24, 19 ..., and that death occurred, on the date stated above, at 1.35 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) [illegible], M. D.

19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Jan 26 1924

UNDERTAKER Wm Fackenthal Sons

ADDRESS N & Pa

B.—WRITE PLAINLY, WITH UNFADING INK—T
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

Spec.—1-10-21—M&T—1500 Bks.

D 83090

HEALTH DEPARTMENT—CITY OF BALTIMORE

14-001

D 83090

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Madison ave ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timmie Watson Smallwood

(a) RESIDENCE NO. 1010 Madison ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Lockhart Smallwood

6 DATE OF BIRTH (month, day, and year): Aug 20 1856

7 AGE: Years 67 Months 5 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Nurse

9 BIRTHPLACE (city or town) (State or country): Windsor NC

PARENTS

10 NAME OF FATHER: James D. Groors

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Amanda W. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: W. Howard Smallwood

(Address) 1010 Madison ave

15 JAN 25 1924 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25 1924

17 I HEREBY CERTIFY, That I attended deceased from ..... 1905 ..... to Jan 25 1924, that I last saw her alive on Jan 24 1924 at 11 am and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Central ~~hemiplegia~~ Hemorrhage.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cerebral paralysis

(Signed) Jno A Lentscher, M. D.

Jan 25, 1924 (Address) 1025 Madison ave. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jany 28 1924

20 UNDERTAKER: W. J. Thomas Sons — ADDRESS: Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 25 1924

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83091

CERTIFICATE OF DEATH.

Old Franklintown Rd 100-09 D 83091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklintown Balto ST., 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Dawson

(a) RESIDENCE NO. Franklintown Balto ST., 28 WARD Patapsco Md.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice V. Dawson

6 DATE OF BIRTH (month, day, and year) Dec 8 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. K. Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry H. Dawson

(Address) Franklintown

15 Filed JAN 25 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany 22, 1924, to Jany 27 1924

that I last saw he alive on Jany 24, 1924

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Hanover a a Co Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. F. Overhalt M. D.

Jan 25 1924 (Address) Woodlawn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Jan 28 24

20 UNDERTAKER Wm McKnew ADDRESS Govans Md

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83092

D 83092

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Parks

(a) Residence No. 219 W. Hamburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1872

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Philip Parks

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, Registrar.

Filed ..... 192.....

JAN 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 19 19 24 to January 25 19 24

that I last saw him alive on January 24 19 24

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic aortitis; Aortic

insufficiency; Myocardial insufficiency

(Duration) yrs. 3 mos. (Estm.)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Bruce M. D

1-25-49 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Interred	Jan 28 1924

20-UNDERTAKER, C. H. Brown & Son ADDRESS 1080 N Monroe St

I.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83093

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH: [redacted] HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Isabelle Bridget

(a) RESIDENCE No. 1233 E. Lexington St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept ? 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	3	4	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Bridget

11 BIRTHPLACE OF FATHER (city or town) (State or country) M. D.

12 MAIDEN NAME OF MOTHER Bertha Geeyes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk

JAN 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1924, to Jan 25, 1924.

that I last saw h[illegible] alive on Jan 25, 1924.

and that death occurred, on the date stated above, at 3 15 A m.

The CAUSE OF DEATH* was as follows:

Scarlet fever - 3 wks ?

Secondary pneumonia - 5 ds.

Gangrene of skin - 4 ds.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. A. Wreech M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn cemetery	Jan 26 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83094

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1907 E. Chase ST., 8 WARD)

2-FULL NAME Elizabeth McGrath

(a) RESIDENCE NO. 1907 E. Chase ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 18-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edw. McGrath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Delhi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Howard.
(Address) 1907 E. Chase St

15 Robert P. Harrison, Registrar

JAN 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923, to Jan 25, 1924, that I last saw h[illegible] alive on Jan 24 1924, and that death occurred, on the date stated above, at 4 10 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr M. D.

1/25, 1924 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Jan 28 1924

20 UNDERTAKER Geo M. Fritz Son — ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83095

CERTIFICATE OF DEATH.

90 D 83095

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kress

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Kress

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	48	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife of Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) (?)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) (?)

14 Informant Records Mt Hope Retreat
(Address) Mt Hope Balto Md

15 JAN 26 1924 Robert T. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1924

17 I HEREBY CERTIFY, That I attended deceased from 1906 May 13th to Jan 24 1924, that I last saw h[illegible] alive on June 23rd 1924, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

abt (duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Chr. Diff. Pyelitis

abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Jan 24th 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 28 1924

20 UNDERTAKER Jos. L Herr & Son ADDRESS 156 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D.83096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.83096

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N. Castle ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund Icenroad.

(a) RESIDENCE NO. 526 N. Castle ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1923

7 AGE: Years | Months 1 | Days 5 | If LESS than 1 day, ...hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Icenroad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant William Icenroad

(Address) 526 N. Castle St.

JAN 26 1924

Filed ....., 19.... Robert F. Haffner, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924, to Jan 24, 1924,

that I last saw him alive on Jan 24, 1924,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. A. Dreyer, M. D.

, 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: Jan 26 1924

20 UNDERTAKER: Christian Miller

ADDRESS 2338 Jefferson St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83097

D 83097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Vincent ST. 16 WARD)

2-FULL NAME Mary Matthews

(a) RESIDENCE. NO. 917 N. Vincent ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Matthew.

6 DATE OF BIRTH (month, day, and year) July 1-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cohen's Bo Md

9 BIRTHPLACE (city or town) Unknown Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country)

14 Informant Wm Matthews
(Address) 917 N. Vincent St

15 Filed ..... 19 Robert P. Harrison Registrar

JAN 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1924 to Jan 23 1924, that I last saw h. alive on Jan 23 1924, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypostasy.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) E. L. Leuch, M. D.

Jan 24 1924 (Address) 1417 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan. 26 1924
20 UNDERTAKER	ADDRESS
A. Jones	1113 Gilmor St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83098

CERTIFICATE OF DEATH.

49 D 83098

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 St Mary ST., 11 WARD)

2-FULL NAME Charles Glasgow

(a) RESIDENCE NO. 414 St Mary ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M Glasgow

6 DATE OF BIRTH (month, day, and year) Sept 20 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor 086
(b) General nature of industry, business, or establishment in which employed (or employer) Janitor of Bank
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Maryland

14 Informant Annie M. Glasgow
(Address) 414 St Mary

15 Date received JAN 26 1924 Robert P. Harrison, Registrar
Local Registrar or Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 3, 1924, to Jany 23, 1924, that I last saw him alive on Jany 23, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate & Cystitis (duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E Mackenzie M. D.

1/26, 19 24 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Law.	1/26, 1924
20 UNDERTAKER Samuel I Hemsley	ADDRESS 538 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83099

CERTIFICATE OF DEATH.

100-00

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Park Ave ST., 11 WARD)

2-FULL NAME Larrie P. Washington

(a) RESIDENCE NO. 1010 Park Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Henry Washington

6 DATE OF BIRTH (month, day, and year) Oct 16, 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Rappahannock Co
(State or country) Va

PARENTS

10 NAME OF FATHER Frank Landor

11 BIRTHPLACE OF FATHER (city or town) Rap. Co.
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Rap. Co
(State or country) Va

14 Informant Henry Washington
(Address) 1010 Park Ave

15 Filed JAN 26 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, 1924 to Jan 24, 1924, 1924
that I last saw h[illegible] alive on Jan 24, 1924
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Observed

(Signed) A Lee Ellis, M. D.

1/25, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 1/27 1924

20 UNDERTAKER Samuel Kennedy

ADDRESS 5787 Biddle St

D 83100

Stock 6-8-24—H. & P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83100

CERTIFICATE OF DEATH.

155

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Boyd ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mc Dowell

(a) RESIDENCE. NO. 913 Boyd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Wm. Mc Dowell

6 DATE OF BIRTH (month, day, and year): July 4-1880

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
43	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Easton Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Wm Mc Dowell 913 Boyd St

15 Filed JAN 28 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1 1924, to Jan 23 1924, that I last saw him alive on Jan 23 1924, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Otitis Mycletis of Jaw

(duration) yrs. one mos. 23 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) Hallock M. D.

Jan 24 (Address) 908 Mc H. Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: 1/26 1924

20 UNDERTAKER: Samuel Kingsley — ADDRESS 578 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

132 D 83101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Bolton St ST., 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Keating Stuart

(a) RESIDENCE NO. 1530 Bolton St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 7th 1848

7 AGE: Years 76; Months ...; Days ...; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary-Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer): Consolidated Coal Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: Wm K Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Susan M. Keating

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Miss Stuart
(Address): 1530 Bolton St

15 Filed JAN 28 1924 19 ... Registrar ...

Robert P. Harrison
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1922, to Jan 26, 1924, that I last saw h. in alive on Jan 26, 1924, and that death occurred, on the date stated above, at 6.45 PM

The CAUSE OF DEATH* was as follows:

Toxemia (Uremia)
Pyelonephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension, Prostate, Cystitis

(duration) 3 yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) O. J. Underhill, M. D.

19 (Address) 1800 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Jan 28 1924

20 UNDERTAKER: Geo. A. Jenkins & Son Co. — ADDRESS: Orchard & Fawn Sts

Spec.—6-9-19—H. P. Co.—1000 Eks.

D 83102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83102

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1553 Woodyear ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Gryden

(a) RESIDENCE. NO. 1553 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Green Both dead.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Arthur Beadle
(Address) 1201 Whatcoat St.

15 Filed JAN 26 1924 19 Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1923, to Jan. 22, 1924, that I last saw him alive on " " 1924, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Sputum.

(Signed) John D. Dennis, M. D.

(Address) 1377 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lubrun Cemetery	Jan 27 1924

20 UNDERTAKER Jas H Dennis ADDRESS 1377 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 D 83103

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jean Baylin

(a) RESIDENCE No 2409 Lakeview Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Baylin

6 DATE OF BIRTH (month, day, and year) Sept. 19/1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Louis Silberstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Freda Marks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Louis Silberstein (Father) (Address) Brooklyn N.Y.

15 Filed JAN 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia & Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Nephritis-Bichloride Mercury Poison-Probably Accidental

(Signed) J. S. Weller, M. D. (Coroner.)

Jan 25/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City N.Y. DATE OF BURIAL 1/26 1924

20 UNDERTAKER Jack Levis ADDRESS 1437 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83104

CERTIFICATE OF DEATH.

86-001

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 14 Ward

2-FULL NAME Mary Ethel Krouse

(a) RESIDENCE No. 1401 Division St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): ?

7 AGE — Years: X — Months: 4 — Days: ? — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): ?

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Records (Address) Johns Hopkins Hospital

15 Filed JAN 24 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 19 23, to Jan 17, 19 24.

that I last saw her alive on Jan 12, 19 24.

and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 3 mos ? ds.

CONTRIBUTORY (Secondary): Otitis media

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? St Vincents Infant Asylum

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Mesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Hospital — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83105

CERTIFICATE OF DEATH.

154002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 Mosher ST. 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hudson

(a) RESIDENCE NO. 138 Mosher ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 24-1924

7 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Spilman Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mabel A. Madell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. J. S. Hudson

(Address): 138 Mosher St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Via. Chesapeake Steamship Co. C/o Wm C. Hudson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24. 1924. to Jan 26. 1924.

that I last saw him alive on Jan 25. 1924,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mm. Gloom of Stomach Cole

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

1/26. 1924 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gloucester Point. Va Gloucester Co

DATE OF BURIAL: Jan 26 1924

20 UNDERTAKER: Concord & E North

ADDRESS: C/o Wm C Hudson

JAN 26 1924

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUARANTINE is very important. See instructions on back of certificates.

KODAK

Spec.—1-10-21—M&T—1500 Bks.

D 83106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83106
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4025 Old York Rd ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel D. Bradford

(a) RESIDENCE No. 4025 Old York Rd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Belle Bradford

6 DATE OF BIRTH (month, day, and year) May 30-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	75	8.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draftsman

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer Balto Eng. Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dr Chas Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francis Drew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary B. Bradford
(Address) 4025 Old York Road

15 Filed ....., 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Jan 25, 1924, that I last saw h alive on Jan 24, 1924, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) H. S. Wheaton, M. D.

, 19 (Address) 4239 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery Md	Jan. 28 1924

20 UNDERTAKER Woodcock ADDRESS 502 E. Fayette

~~Burial Permit Clerk~~

To John L Bowes. Via P.R.R. Co.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Duncan 5106 York Road

D 83107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 502 Ravens wood Ave St., 27 57 Ward.

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Massimo Pisani

(a) Residence No. 502 Ravens wood Ave St., Govans Ward.
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Pisani

6-DATE OF BIRTH (month, day and year) Dec 23 1867

7-AGE, 76 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 045

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Egisto Pisani

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Marie Pisani

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy

14- (Informant) Massimo Pisani (Address) 502 Ravens wood Ave Govans

15- Filed..... Robert P. Harrison, Registrar.

JAN 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 8th, 1923, to Jan 25, 1924, that I last saw him alive on Jan 25, 1924, and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis complicated with Diabetes

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Jan 26, 1924 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery — DATE OF BURIAL, 1/29, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Nav

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83108

CERTIFICATE OF DEATH.

91 607 D 83108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N. Bray ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Madagan

(a) RESIDENCE No. 146 N Bray ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of John E. Madagan

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE: 91 — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. (Good)

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): St. Michaels Md.

PARENTS

10 NAME OF FATHER John. Blades

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Michaels Md.

12 MAIDEN NAME OF MOTHER Elizabeth Somers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co. Md.

14 Informant: Mr. Clinton Blades Md

(Address) 143 N. Bray Baltimore

15 Filed JAN 28 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to Jan 25, 1924, that I last saw h[illegible] alive on Jan 25, 1924 and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. 7 mos. X ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Exam.

(Signed) Clinton E. Blades, M. D.

1/25/1924 (Address) 143 N. Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Michaels, Md

DATE OF BURIAL: 1/24 1924

20 UNDERTAKER: J. A. Groan

ADDRESS 3000 E. Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83109

D 83109

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. #1640 Hanover ST.: 23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Remmers.

(a) RESIDENCE. NO. #1640 Hanover ST., 23. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 92 yrs. mos. 13. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female,	White,	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Remmers.

6 DATE OF BIRTH (month, day, and year) Jan.13,1831.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	92,		13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Adolph Dreacher.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Louisa Archibald.
(Address) #1640 Hanover St.

15 Filed JAN 26 1924, 19.. Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1924, to Jan 26, 1924, that I last saw h alive on Jan 25, 1924 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

Jan 26 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 28 1924
20 UNDERTAKER	ADDRESS
A Howard Evans	1428 Charles St

JAN 26 1924

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83110

CERTIFICATE OF DEATH.

101-006 D 83110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Washington

(a) RESIDENCE NO. 912 W. Lexington st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ward maid 070

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Bob Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M. T. H.

15 FEB 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1924, to Jan. 24, 1924, that I last saw h. alive on Jan. 24, 1924, and that death occurred, on the date stated above, at 9.35 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. A. Lally, M. D.

1-25-24, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cem	1-28 1924
20 UNDERTAKER	ADDRESS
Geo. T. G. Gibson	1735 Druid Hill Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

168987 D 83111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 44 D 83111

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mr Edward P. Leilous.

(a) RESIDENCE NO. Belmont, N. Y. ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —0—

(c) Name of employer —0—

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John Leilous

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Sophrane Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL.

15 Filed JAN 27 1924, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 19 24

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 19 24 to Jan 26, 19 24

that I last saw him alive on Jan 26, 19 24

and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Retro Visical Lymphoma, with involvment of bladder. Metastasis to Lungs Liver &c.

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Shock following X-Ray treatment? dup

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Buffalo

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Winfield W. Scott, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Belmont New York	Jan. 26 1924
20 UNDERTAKER	ADDRESS
Wm E. Black	927 N. Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83112 — 3 — D 83112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospi ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Mitchell

(a) RESIDENCE NO. 19 S. Albemarle st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 32 mos. ds. How long in U. S., if of foreign birth? Unknown yrs. 20 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 669

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Tons Makaras

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Marta Jogmanas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1924, to Jan. 24, 1924,

that I last saw h 9r alive on Jan. 24, 1924,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lallip, M. D.

1-24-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Jan. 29 1924
20 UNDERTAKER	ADDRESS
John Gobliauskas	1165 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83113

CERTIFICATE OF DEATH.

129 D 83113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 675 W Barre ST., 27 WARD)

2-FULL NAME Vincent Sankus

(a) RESIDENCE No. 675 W Barre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE 77 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Notknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Notknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant K. Firsuk
(Address) 675 W Barre Street

15 JAN 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 23, 1924, that I last saw h[illegible] alive on Jan 23, 1924 and that death occurred, on the date stated above, at 1. A. M. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dyspnea

(Signed) Malcolm Hoge, M. D.

1/25, 1924 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan. 28. 1924

20 UNDERTAKER: John Gobbiewicz — ADDRESS: 425 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83114

129 D 83114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 McCulloh ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Tyler

(a) RESIDENCE. No. 2527 McCulloh ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Tyler

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE: Years 74 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Tyler

(Address) 2623 N. McCulloh St.

15 Filed JAN 27 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 16th, 1923, to Jan 24, 1924

that I last saw h alive on Jan 24, 1924

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray, M. D.

1-26, 1924 (Address) 510 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem

DATE OF BURIAL: 1/27 192

20 UNDERTAKER: Saml Weinberg

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83115 | CERTIFICATE OF DEATH. | 58-001 | D 83115

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 668 W. Mulberry St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Williams

(Residence in Baltimore: No. 668 W. Mulberry St.; 10 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1886 (Year)

7-AGE, 38 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): New Jersey

PARENTS.

10-NAME OF FATHER: Hugh W Thompson

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Jane Briscoe

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Williams

(Address) 668 W Mulberry St

15- JAN 27 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1923, to Jan 25 1924, that I saw h[er] alive on Jan 25 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

..... (Duration) ..... yrs. 2½ mos. ..... da.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ? da.

(Signed) H. E. Krug M. D.

1/27, 1924 (Address) 637 Mosher St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Washington D.C. DATE OF BURIAL: 1/29, 1924

20-UNDERTAKER: Samuel Hawley ADDRESS: 578 N Eden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83116 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 83116

CERTIFICATE OF DEATH.

14 161-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2135 Linden Avenue St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Meyer

(a) Residence No. 2135 Linden Avenue St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year): Jan. 26-24

7-AGE: .....yrs. .....mos. .....ds. If LESS than 1 day, 4 hrs. or .....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS:
10-NAME OF FATHER: Herman Meyer
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md
12-MAIDEN NAME OF MOTHER: Etta Rife
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto., Md

14- (Informant) J. Lewis, (Address) 1439 E. Balto. St.,

15- Filed JAN 27 1924 19.. ROBERT A. KRAMER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 27. 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 27, 1924, that I last saw h. alive on Jan 26, 1924, and that death occurred, on the date stated above, at 1 A. m.
The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. 4 hrs ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Michael A. Abrams M. D.
Jan 27, 1924 (Address) 1360 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Hebrew Southern Ave.	1-27 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E. Balto. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Blks.

Robert G. Harris

D 83117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83117

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert G Harris

(a) RESIDENCE NO. 1706 Argyle St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ester Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Charles W Harris

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary E Burick

13 BIRTHPLACE OF MOTHER (city or town) Balt Md (State or country)

14 Informant University Records (Address) Lombard & Green Sts

15 Filed JAN 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/11/24, 19, to 1/26, 1924.

that I last saw he alive on 1/26/1924, 19

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sub acute Nephritis. (duration) Not Known yrs. mos. ds.

18 Where was disease contracted if not at place of death? not Known

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Blood

(Signed) W Wallace Walker, M. D.

, 19 (Address) University Hospital Lombard & Greene Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	1/29 1924
20 UNDERTAKER	ADDRESS
H. C. Mudefield	914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

D 83118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 100-001 ✓ D 83118

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N. Exeter ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Joseph Bastable

(Residence in Baltimore: No. 426 N. Exeter St.; 32 yrs., \ mos. \ da.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 9th, 1892 (Month) (Day) (Year)

7-AGE 31 yrs. 11 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto City.

PARENTS.

10-NAME OF FATHER, John H. Bastable

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Mary Agnes McMahon

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. B. Saunders

(Address) 719 E. Preston St.

15- JAN 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 24th, 1924 (Month) (Day) (Year)

17) I HEREBY CERTIFY, That I attended deceased from Jan 6th 1924, to Jan 24 1924, that I saw him alive on Jan 23 1924, and that death occurred, on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Sub-Acute Bronchitis

(Duration) 1 yrs. \ mos. \ ds.

(Signed) E. B. Saunders M. D.

Jan 27th, 1924 (Address) 719 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross DATE OF BURIAL, Jan 28, 1924

20-UNDERTAKER H. C. Middefeld & Son ADDRESS 914 Greenmount Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83119

CERTIFICATE OF DEATH.

181-001 ✓ D 83119

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 N. Chapel) Pronounced dead at Johns Hopkins Hospital (WARD) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert T. Hlavinka

(a) RESIDENCE No 933 N. Chapel St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 24/1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Hlavinka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie Zelena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Thomas Prucha
(Address) 933 N. Chapel St.

15 Filed JAN 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation
Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism (duration) yrs. mos. ds.

(Signed) J. M. Collins (Coroner.), M. D.

Jan 25/24 (Address) 508 E. Northelve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 28 1924
20 UNDERTAKER	ADDRESS
Frank Crockson	1900 Eastland

MAKE ENTRIES BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83120

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

100-001 ✓ D 83120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Castiglione

(a) RESIDENCE No. 1115 E. Pratt ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 11-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 6mo

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Anthony Castiglione

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Alisio

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mrs Anthony Castiglione
(Address) 1115 E Pratt

15 Filed JAN 27 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1924 11 a.m. 19 24, to Jan 26 1924 11 p.m. 19 24.

that I last saw h alive on Jan 25, 19 24,

and that death occurred, on the date stated above, at 11:25 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Probably Primary

(duration) yrs. 6 days mos 3 ds.

CONTRIBUTORY
(Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Isidor L. Fox, M. D.

Jan. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL Jan 28 1924

20 UNDERTAKER Geo Lowe & Son ADDRESS 701 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83121

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Inc. Henry ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Bily

(a) RESIDENCE NO. 1827 Inc. Henry st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Bily

6 DATE OF BIRTH (month, day, and year) Feb. 1/1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Jos. Bily (Address) 1827 Inc. Henry st.

15 JAN 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1923 to Jan 27 1924 that I last saw h[illegible] alive on Jan 24 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

1 Natural Respiratory

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arter Cir Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) [illegible] M. D.

, 19 (Address) 600 Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem DATE OF BURIAL Jan 28 1924

20 UNDERTAKER Jos. J. Kerr & Son ADDRESS 156 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83122

46

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 S Carrollton ST., 18 WARD)

2-FULL NAME Marguerite A McElroy

(a) RESIDENCE No. 34 S Carrollton ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 year mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John McElroy

6 DATE OF BIRTH (month, day, and year) Nov 5 1890

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	33	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm B Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John McElroy
(Address) 34 S Carrollton Ave

15 Filed JAN 27 1924 Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/24

17 I HEREBY CERTIFY, That I attended deceased from 3/20/23, 19..., to 1/25/24, 19...,
that I last saw h— alive on 1/25/24, 19...,
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:

Cachexia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cancer (Sarcoma of Uterus (mets.))

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 3/23 -

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Section

(Signed) E A Warren, M. D.

1/26 1924 (Address) 806 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 1/27 1924

UNDERTAKER Wm A Smith Funeral Home — ADDRESS Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83123

CERTIFICATE OF DEATH.

31

D 83123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 Whakeat St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Golding

(a) RESIDENCE NO. 1330 Whakeat St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Golding

6 DATE OF BIRTH (month, day, and year) July 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chas Co Md

PARENTS

10 NAME OF FATHER William Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chas Co Md

12 MAIDEN NAME OF MOTHER Mary Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chas Co Md

14 Informant James Golding

(Address) 1330 Whakeat St

15 Filed JAN 27 1924 19 ROBERT R. KRAUTER Burial Permit Clerk. Remark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1923, to Jan 25, 1924, that I last saw h[illegible] alive on Jan 24, 1924, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Intestinal Tuberculosis (duration) yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

Jan 26, 1924 (Address) 1209 Preston Ave St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cha Co Md	Jan 28 1924

20 UNDERTAKER	ADDRESS
Florence E. Wright	1364 Pearre

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 83124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 83124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Hillen St ST., 5 WARD)

2-FULL NAME Richard A Tucker

(a) RESIDENCE No. 909 Hillen St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2nd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Robt Louis A Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Betsey Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Valiny Howard

(Address) 709 Hillen St

15 FILED JAN 27 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1923, to Jan 25 1924, that I last saw h[illegible]ive on Jan. 23, 1924, and that death occurred, on the date stated above, at 9:20A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Rt Sided Paresis.

(duration) 1 yr. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wm H Wright M. D.

(Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 28th 1924
20 UNDERTAKER	ADDRESS
Samuel Enright	1364 Mary

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83125

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 635 N. Calhoun St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerhard F. Kooke

(a) Residence No. 635 N. Calhoun St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6-DATE OF BIRTH (month, day and year) Nov. 5-1851

7-AGE. 72 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Real Estate &

(b) General nature of industry, business, or establishment in which employed (or employer) Investments

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, J. H. G. Kooke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Amelia Gude

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Chas. F. Kooke

(Address) 635 N. Calhoun St

15-

Filed ..... 192.... ROBERT P. KRAUTER, Registrar.

JAN 27 1924

Deputy Health Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 29 1923 to Jan 25 1924

that I last saw h alive on Jan 24 1924,

and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips M. D

Jan 25 1924 (Address) 1929 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Jan 28 1924
20-UNDERTAKER, Chas. E. Franck	ADDRESS for Madison Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83126

CERTIFICATE OF DEATH.

D 83126

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

2-FULL NAME Mrs Mary Alberta Eschelman

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr Eschelman

6 DATE OF BIRTH (month, day, and year) Oct 8, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	66	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (?)
(State or country) Maryland -

PARENTS

10 NAME OF FATHER Simon Carfora

11 BIRTHPLACE OF FATHER (city or town) "Carfora"
(State or country) Md -

12 MAIDEN NAME OF MOTHER Margaret McGuire

13 BIRTHPLACE OF MOTHER (city or town) "Carfora"
(State or country) Md -

14 Informant Records of Mt Hope Retreat
(Address) Baltimore Md -

15 Filed JAN 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 19 24

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1923, to Jan 26, 1924,

that I last saw h[illegible] alive on Jan 26, 1924,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

Abt (duration) 0 yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Delusional Psychosis

Abt (duration) 0 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	Jan. 28 1924
20 UNDERTAKER	**ADDRESS**
Wm Cook	502 E Fayette

Spec.—1-10-21—M&T—1500 Blks.

D 83127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 D 33127

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33 W Calvert St ST., 96 WARD)

2-FULL NAME Charles Louis Hess

(a) RESIDENCE NO. 937 Gorsuch Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 07 '23

7 AGE: Years | Months: 5 | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Louis Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant W Norwood Hospl.
(Address)

15 Filed JAN 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Jan 26, 1924, that I last saw him alive on Jan 25, 1924, and that death occurred, on the date stated above, at 8 24 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Bad c of L. Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F. A. Rothgeb, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Jan 29 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09 ✓ 83128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wyatt

(a) RESIDENCE NO. 1823 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia A Wyatt

6 DATE OF BIRTH (month, day, and year): Sept 26 1850

7 AGE: 73 Years | Months 4 | Days | If LESS than 1 day, hrs. or min.

78 | 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Order by Doctor

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: Hebrew Hospital

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Alexandria to Wyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah A Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs E W Hartogs (Address): Eutaw Hall

15 Date: JAN 27 1924 ROBERT R. KRAUTER, Registrar

Health Department Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1924 to Jan 26, 1924.

that I last saw him alive on Jan 26, 1924

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho) Type III

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor L. Fox, M. D.

Jan 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Jan

DATE OF BURIAL: 28 1924

20 UNDERTAKER: Wm Cook

ADDRESS: 55 2 E Pratt Blvd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

83129 ✓ 11-06 83129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Woodburne Ave Govans St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Riley

(a) Residence No. Woodburne Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Riley

6-DATE OF BIRTH (month, day and year) May-9-1859

7-AGE, 66 yrs. 8 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Robert Orem

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Theodore Riley

(Address) Woodburne Ave

15-

Filed JAN 27 1924, 192 ROBERT M. BRAUER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 26-24

17- I HEREBY CERTIFY, That I attended deceased from Jany 1, 1924, to Jan 26, 1924, that I last saw h.. alive on Jan 26, 1924, and that death occurred, on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

La Grippe, 1 wk.

Contrib. Senile & Cerebro Chronic

Cardiac & Nephritic & Cerebro

Arter. & Hillalar - Enlarged & de

Called heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo A Hoskins, M. D.

, 19 (Address) 5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Parkwood	Jan 29, 1924
20-UNDERTAKER,	ADDRESS
William Cook	502 E North Ave

IMPORTANT—PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 83130

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park View Sanitarium ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Dreu Truman

(a) RESIDENCE NO. 3638 Abell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcia Truman

6 DATE OF BIRTH (month, day, and year) Feb 25 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	94	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathaniel Truman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Drew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. E. Lauer 3638 Abell Ave

15 Date JAN 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923 to Jan 26, 1924.

that I last saw him alive on Jan 24, 1924

and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Test - Albumen

(Signed) R. L. Shepard, M. D.

(Address) 3638 Abell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Plymouth Mass

DATE OF BURIAL Jan 27 1924

20 UNDERTAKER Robt J Turner Inc

ADDRESS 17 W Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

83130

16885 83131

HEALTH DEPARTMENT—CITY OF BALTIMORE

83131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST., WARD)

2-FULL NAME Alfred Kemp

(a) RESIDENCE NO. 342 Madison St (Usual place of abode) Ne Lenoch, Md ST., WARD

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Florence Kemp

6 DATE OF BIRTH (month, day, and year) Feb 11, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William H Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Brangle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JAN 27 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Jan 27, 1924

that I last saw him alive on Jan 27, 1924

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

½ hour (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Winfield M. Scott M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick City Md — DATE OF BURIAL 19

20 UNDERTAKER Joseph B Cook — ADDRESS 1006 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

D 83132

CERTIFICATE OF DEATH.

D 83132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Preston St. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah C. Girnell

(a) RESIDENCE NO. 231 N. Preston St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1854 Guess

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Anna Hall
(Address) 1121 Division St.

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas. (Illuminating gas.)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) accidental (Gas heater)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

Jan. 25, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Catholic

DATE OF BURIAL 1-28 1924

20 UNDERTAKER Dan Easton

ADDRESS 916 Pine

mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16910 D 83133 — D 83133 — 100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH [redacted] HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST. 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Smith

(a) RESIDENCE No. 1841 Kavanaugh St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 4, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X	2.	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Grace Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Information furnished by Records JOHNS HOPKINS HOSPITAL.
(Address)

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1924 to Jan 25, 1924, that I last saw her alive on Jan 25, 1924, and that death occurred, on the date stated above, at 3 45 m.

The CAUSE OF DEATH* was as follows:
Ulcerative Stomatitis (Vincent's)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acute bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bagg M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1-28 1924

20 UNDERTAKER [redacted] — ADDRESS 916 [redacted]

Spec– 12-23-21–E.B.R.S.–400 Eks.

83134

HEALTH DEPARTMENT—CITY OF BALTIMORE

83134

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mary Viola Davis St., 10 Ward) 90

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Little Lilly of Bet Car

(a) Residence No. Preston Valley St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Wid W

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of George Davis.

6-DATE OF BIRTH (month, day and year) Unknown

about 5-9 Unknown yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Eastern Shore Md

PARENTS.

10-NAME OF FATHER. Wm Wallace

11-BIRTHPLACE OF FATHER (city or town) (State or Country). St Mary's Md

12-MAIDEN NAME OF MOTHER. Johanna Dunn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). St Mary's Md

14-

(Informant). Sister In Law

(Address). Preston & Valley

15- JAN 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan'y 27/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 23rd 19.. to .. 19..

that I last saw h.. alive on Jan'y 26 1924

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Browne M. D

Jan'y 27/24 19 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral

DATE OF BURIAL, Jan 29 19 24

20-UNDERTAKER. Wm Cook

ADDRESS 502 E Fayette

(1) IMPORTANT. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83135

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 W Mulberry ST., 17 WARD)

2-FULL NAME Hazel Olive Johnson

(a) RESIDENCE NO. 414 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis Johnson

6 DATE OF BIRTH (month, day, and year): Oct 15, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House 048

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Private mk

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: J. Perry Baber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lula Sheddan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: J. Perry Baber
(Address) 414 W Mulberry

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 26 19

17 I HEREBY CERTIFY, That I attended deceased from Jan ....., 1923, to Jan 26, 1924, that I last saw her alive on Jan 26, 1924 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Walter C Bacon, M. D.

1/27, 1924 (Address) 1002 20

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brandywine Md

DATE OF BURIAL: 1/29 19 24

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Nad

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83136

CERTIFICATE OF DEATH.

57 D 83136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 850 W. Lombard ST., 18 WARD)

2-FULL NAME Annie Johnson

(a) RESIDENCE No. 850 W. Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Johnson

6 DATE OF BIRTH (month, day, and year) Oct 7. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth McFee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant W. F. Johnson (Address) Clifton Forge Va

15 Filed JAN 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27. 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Jan 27, 1924, that I last saw her alive on Jan 27. 1924, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar E. Travers, M. D.

, 19 (Address) 1503 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clifton Forge Va	Jan 28, 1924
20 UNDERTAKER George J. Smith	ADDRESS 1582 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83137 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence M Smith.

(a) RESIDENCE NO. Howardville, Baltimore County, Md. Balto. Co.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Smith

6 DATE OF BIRTH (month, day, and year) May 18-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER A. A. Hoover

11 BIRTHPLACE OF FATHER (city or town) Hagerstown (State or country) Md

12 MAIDEN NAME OF MOTHER Minerva Robinson

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant B Magowan

(Address) Sydenham Hospital

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1924, to Jan 26, 1924.

that I last saw her alive on Jan 26, 1924,

and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B Magowan, M. D.

1/26/24 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery Jan. 28,	1924

20 UNDERTAKER	ADDRESS
Wm. Cook	502 East Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 83138

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 83138

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME James C Franklin

(a) RESIDENCE NO. Bay View Asylum ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Franklin

6 DATE OF BIRTH (month, day, and year) April 10 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	9	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James A. Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Municipal Hospital Records
(Address)

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-15 , 1923 , to 1-26 , 1924, that I last saw h alive on 1-26 , 1924; and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude A. Vrace, M. D.

1-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbury Chapel Reisterstown	Jan 29 1924
20 UNDERTAKER	ADDRESS
A Howard Evans	1428 E. Chas St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83139

101-001

D 83139

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Bolton St. 14 WARD)

2-FULL NAME Mary Ellen Slow

(a) RESIDENCE NO. 1530 Bolton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 60 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): O.H.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Josephine Simms

(Address) 1121 Bolton St

15 Filed JAN 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 16th, 1924 to Jan. 25th, 1924

that I last saw her alive on Jan 24th, 1924

and that death occurred, on the date stated above, at 11:25 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos 3 ds.

..... (duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

1/25, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Jan 28 1924

20 UNDERTAKER: Chas Alexander & Sons

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 70 WARD)

2-FULL NAME Edward A Hand.

(a) RESIDENCE No. 208 N. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Me.	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Layne.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk ofd

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer Krauss Sanitary Plumbing Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Katharine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Katharine Hand

(Address) 154 W. Royal Ave

JAN 28 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924.

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1924, to Jan 26, 1924, that I last saw h[illegible] alive on Jan 26, 1924, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John G. Schaupp M. D.

19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/29 1924
20 UNDERTAKER	ADDRESS
Henry W. Meas & Son	505 W. Saratoga St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83141

CERTIFICATE OF DEATH.

36 D 83141

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St. Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lyons

(a) RESIDENCE NO. St Agnes Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9j yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF [illegible] Ireland

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ellen Ronyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Lyons

(Address) St Agnes Hospital

15 Filed JAN 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1918, to Jan. 26, 1924, that I last saw h[illegible] alive on Jan 26, 1924, and that death occurred, on the date stated above, at 12.5 a. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Tbc osteomyelites

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/16/21

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Harper M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Jan 29 1924

20 UNDERTAKER N Tuckey Sons.

ADDRESS 827 N North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83142

CERTIFICATE OF DEATH.

46 D 83142

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Fr. Sq. Hosp.

CITY OF BALTIMORE: (No. 100 N. Calhoun ST., 17 WARD)

2-FULL NAME Columba Elizabeth Stansbury

(a) RESIDENCE No. 2805 Hampden ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) M

If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. L. Stansbury

6 DATE OF BIRTH (month, day, and year) Mar 8, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home. 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Frederick Co, Md

PARENTS

10 NAME OF FATHER Jos. W. Davidson

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Wolfe.

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co. (State or country) Md.

14 Informant (Address) Chas. L. Stansbury 2805 Hampden

15 Filed JAN 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26/24. 19

17 I HEREBY CERTIFY, That I attended deceased from 1/16, 1924, to 1/26, 1924, that I last saw her alive on 1/25, 1924, and that death occurred, on the date stated above, at 4.55 a. m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of uterus.

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Routine Lab. tests

(Signed) Douglass A. Haddock, M. D.

, 19 (Address) Fr. Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan. 29 1924

20 UNDERTAKER Horace F. Burgee — ADDRESS 363 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Moger

D 83143

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH.

D 83143

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2501 West Fairmount Avenue 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wallace Moger

(a) Residence No. 2501 West Fairmount Avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Tillie M. Moger

6-DATE OF BIRTH (month, day and year) May 25, 1872

7-AGE.	If LESS than 1 day.
51 yrs. 7 mos. 28 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fish Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer

9-BIRTHPLACE (city or town) Long Island (State or Country), New York

PARENTS.

10-NAME OF FATHER, Lorenzo Moger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Mrs. Tillie M. Moger

(Address) 2501 West Fairmount Ave.

15- Filed JAN 28 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 2 19 24 to Jan 28 19 24

that I last saw h. alive on Jan 25 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Arterio Sclerosis 1 Hr

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? High Blood Pressure Ophthalmoscopic Examination

(Signed) Thomas C. Alger M. D.

1-26 1924 (Address) 3640 Roland Avenue

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Jan 28 1924

20-UNDERTAKER.	ADDRESS
Fred B. Cook	1003 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

74 D 83144

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3505 Wallbrook Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marietta F White

(a) Residence No. 3505 Wallbrook ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Welcome White

6-DATE OF BIRTH (month, day and year): Nov 18 1837

7-AGE: 86 yrs. 2 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Vermont

PARENTS.

10-NAME OF FATHER: Davis Read

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont

12-MAIDEN NAME OF MOTHER: Lucinda Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Vermont

14- (Informant) Lelia M. White

(Address) 3505 Wallbrook ave

15- JAN 28 1924 ROBERT R. KRAUTER, Jr. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jany 25/24

17- I HEREBY CERTIFY, That I attended deceased from Jany 6, 1924 to Jany 26, 1924

that I last saw her alive on Jany 23, 1924

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

Duration) yrs mos ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms Paralysis

(Signed) Maurice L. Shamer M. D

1/26, 1924 (Address) 3300 W. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL, Jany 28, 1924

20-UNDERTAKER: John O Mitchell

ADDRESS 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 83145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D 83145

REGISTERED No. C.....

1-PLACE OF DEATH The Mt Royal apartments.

CITY OF BALTIMORE: (No. 103 East Mt Royal Ave. ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Molly Jeffries MacLellan

(Residence in Baltimore: No. Mt Royal apartments St.; 14 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown - ....., 1 .....
(Month) (Day) (Year)

7-AGE, about 50 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, James J Jeffries

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Catherine Smith

13-BIRTHPLACE OF MOTHER (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur R. MacLellan

(Address) Mt. Royal Aparts

15- Filed JAN 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 26, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 15 1923, to January 26 1924, that I saw her alive on January 26 1924, and that death occurred, on the date stated above, at 3:40 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 4 ds.

(Signed) Reginald O. Sellman M. D.

Jan 26, 1924 (Address) Towson, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemy. DATE OF BURIAL, Jan. 28., 1924

20-UNDERTAKER, John O. Mitchell ADDRESS 1201 W. Fayette St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

24 D 83146

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 4214 Springdale Ave 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma C. Wilson

(a) Residence No. 4214 Springdale Ave St., Ward

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, Divorced (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Dr. Harry Wilson

6-DATE OF BIRTH (month, day and year): Aug 21 1868.

7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work: House Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Washington md

PARENTS.

10-NAME OF FATHER: Frisby J. Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country): md

12-MAIDEN NAME OF MOTHER: Harriet Bradford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): md

14-

(Informant): Dr. Harry A. Wilson

(Address) 4214 Springdale Ave

15-

Filed JAN 28 1924 19.. ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/26/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1 1910 to Jan 26 1924

that I last saw h.. alive on Jan 26 1924

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Chronic Myocarditis

(Duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterial Hypertension

3 days (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. T. Quinn M. D

1/28, 1924 (Address) 804 Caldwell Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL, 1924: Jan. 29

20-UNDERTAKER: John O. Mitchell

ADDRESS: 1201 W Fayette St

R. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83147

CERTIFICATE OF DEATH.

99.002

D 83147

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 E. Hoffman ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Cademore

(a) RESIDENCE No. 1512 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Cademore

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Lodisa Bennard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles R. DeShield

(Address) 1512 E Hoffman St

15 Filed JAN 28 1924 ROBERT R. KRAUTER, Register

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 23 1923 to Jan 26 1924

that I last saw her alive on January 25 1924,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Senility, Bronchitis

Infirmities of age,

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hailey H. McMinn M.D.

Jan 25 1924 Address 1011 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Jan 29 1924
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1839 N Balto St., 19 Ward) Registered No. 129

2-FULL NAME Elizabeth Lantz

(a) Residence No. 1839 N Balto St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry Lantz

6-DATE OF BIRTH (month, day and year) Feb 7 1836

7-AGE 87 yrs. 11 mos. 7 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) Baltimore

(State or Country)

PARENTS.

10-NAME OF FATHER Jacob Spitzer

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Kitty Kinsel

13-BIRTHPLACE OF MOTHER (State or Country) Balto Co Md

11-

(Informant) John Daniel

(Address) 1839 N Balto St

15-

FILED JAN 28 1924 ROBERT R. KRAUTER, Registrar of Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 24/24

I HEREBY CERTIFY, That I attended deceased from Jan 22 19 24 to Jan 24 19 24

that I last saw h. alive on Jan 24 19 24

and that death occurred, on the date stated above, at 11.4 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) 10 yrs. ds.

18-Where was disease contracted if not at place of death? (Duration) yrs. 9 mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Fellows M. D.

1/27 1924 (Address) 2724 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Jan 28 1924

UNDERTAKER, J B Hufford ADDRESS 1736 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-091

D 83149

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2817 Boarman ave St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby. Warren

(a) RESIDENCE. No. same 2817 Boarman Ave

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General natnre of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto - md

PARENTS

10 NAME OF FATHER Howard R. Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York N. Y.

12 MAIDEN NAME OF MOTHER R. Myrtle Schwaftzgt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs R Myrtle Warren

(Address) 2817 Boarman ave

15 Filed ..., 19... JAN 28 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26- 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1924 to Jan 26- 1924

that I last saw h[illegible] alive on Jan 22- 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Immaturely born

Foetus 5 Mo. Gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James L. Ashhurst M. D.

(Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cem

DATE OF BURIAL 1/28/ 1924

20 UNDERTAKER David Sondheim

ADDRESS 115 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8-002

118 D 83150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Berard ST., 11 WARD)

2-FULL NAME Maggie M Adams

(a) RESIDENCE No. 1116 Berard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of John W Adams

6 DATE OF BIRTH (month, day, and year) July 29 1846

7 AGE Years 77 Months - Days - If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co (State or country) Pa

PARENTS

10 NAME OF FATHER Wm Marsh

11 BIRTHPLACE OF FATHER (city or town) Lancaster Pa (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Balt Dunno Pa (State or country)

14 Informant John W Adams (Address) 1116 Berard St

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1924, to Jan 25, 1924, that I last saw h[illegible] alive on Jan 25 1924 and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Umbilical Hernia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ralph H G Jones, M. D.

, 19 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Wood Cemetery Inc — DATE OF BURIAL Jany 28 1924

20 UNDERTAKER Robt J Kenedy — ADDRESS 1[illegible] N Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83151

Registered No. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. 1606 E. 25th St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna V. Waller

(a) Residence No. 1606 E. 25th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Charles McWaller

6-DATE OF BIRTH (month, day and year): July 9 55?

7-AGE: 68 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: George Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Larue

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant): Mrs John F. Price

(Address): 1606 E 25th St

JAN 28 1924

Filed ..... 19.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1923, to Jan 26, 1924, that I last saw her alive on Jan 24, 1924, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Microscopic

(Signed) Leonard E. Beach, M. D.

, 19 (Address) 2251 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Bur	Jan 29, 1924
20-UNDERTAKER, W. M. Routson	ADDRESS 2238 N. [illegible]

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 83152

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 83152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 N. Preston ST., 11 WARD)

2-FULL NAME James Alexr Skinner

(a) RESIDENCE No. 321 N. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coachman 23

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer A. Lee Ellis,

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frisby Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rachel Downes

(Address) 457 St Mary St Balto

15 JAN 28 1924 Burial Permit Clerk ROCER K. KNABLER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1923, to Jan 25 1924,

that I last saw h. alive on Jan. 24th. 1924,

and that death occurred, on the date stated above, at 11:35 P. m.

The CAUSE OF DEATH* was as follows:

Pyaemia Streptococcus

Abscess

(duration) 9 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Syphilis Inherited

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

1/25, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 1/28 1924

20 UNDERTAKER Samuel Hensley

ADDRESS 1 E Eddie

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83153

CERTIFICATE OF DEATH.

74-001 D 83153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Fawn ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Grasso

(a) RESIDENCE No. 916 Fawn ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosario Grasso

6 DATE OF BIRTH (month, day, and year) Nov 13th 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	2	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Leonardo Calì

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Salvatrina Pasano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosario Grasso
(Address) 916 Fawn St.

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to her death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. 48 hrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

(Signed) Geo. P. Norton M. D.
(Coroner.)

Jan 25 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths due to violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 28 1924
20 UNDERTAKER	ADDRESS
Wendell Appel & Son	378 N

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17° D 83154

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 E. Lexington ST., 5 WARD

2-FULL NAME Jno. B Phillippa

(a) RESIDENCE NO. 1108 E. Lexington ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — Ex U.S. Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed JAN 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.
ROBERT R. KRAUTER, MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17/ 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by pistol shot wound in brain.

(Duration) minutes yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Riley M. D.

Jan 28, 192 4 (Address) 1059 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	192
20 UNDERTAKER	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Apy.

D 83155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 83155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Harry P. Apy ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 857 W. Lexington

(a) RESIDENCE NO. 857 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29th 1890

7 AGE: 33 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman of Produce

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

066

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry P. Apy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary Hernan

(Address) 857 W Lexington

Filed JAN 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 25, 1924, that I last saw h alive on Jan 25, 1924, and that death occurred, on the date stated above, at 1259 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. found.

(Signed) J. H. Norwood, M. D.

, 19 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Jan 29th 1924

20 UNDERTAKER: H C Brauning Son

ADDRESS 517 N Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83156

CERTIFICATE OF DEATH.

100-001 ✓

D 83156

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 James. ST., 21 WARD)

2-FULL NAME John W. Mcmahan

(a) RESIDENCE NO. 1320 James ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan. 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	0	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John. Mcmahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Evelyn. Schafer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

11 Informant John Mcmahan

(Address) 1320 James

Filed JAN 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26th, 1924, to Jan. 28th, 1924,

that I last saw him alive on Jan 27th, 1924

and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Preliminary)

..... (duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY .....

(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestation

(Signed) Wade C Reynolds, M. D.

, 19 (Address) 101 S Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	1-28 1924
20 UNDERTAKER: James Dignan Son	ADDRESS: 1000 E Pratt St

D 83157

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 83157

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 653 Fulton St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Bates

(Residence in Baltimore: No. 653 Fulton St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col.	Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year)

7-AGE,	If LESS than 1 day,
70 yrs. ..... mos. ..... ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), MD

PARENTS.

10-NAME OF FATHER, Levi Knox

11-BIRTHPLACE OF FATHER, (State or Country), " " "

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER, (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. C. Elliott

(Address) 1725 Eastlandon

Filed JAN 28 1924 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 26 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

..... (Duration) ..... yrs. ..... mos. 2 months ds.

CONTRIBUTORY (Secondary) Heart Block

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

1-28 1924 (Address) 1125 W. Saratoga St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Jan 28 1924
20-UNDERTAKER,	ADDRESS
Mrs. R. C. Elliott	1725 Eastlandon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr S Hemmell 2226 Madison Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83158

CERTIFICATE OF DEATH.

185 D 83158

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1807 Linden Ave St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Camper

(a) Residence No. 1807 Linden Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander Camper

6-DATE OF BIRTH (month, day and year): 1-21-1838

7-AGE: 86 yrs. 10 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Richard Daugherday

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Catherine Harrison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant): Julia Stumbaugh

(Address) 1807 Linden Ave

15- JAN 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 27/1924

17- I HEREBY CERTIFY, That I attended deceased from about a year ago 19..., to Jan. 27, 19 24

that I last saw h.. alive on Jan. 27, 19 24

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Broken hip and infirmity of age

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary): Oedema of lungs

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) S. Hemmell, M. D.

Jan. 28, 1924 (Address) 2226 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Jan 30 19 24

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83159

CERTIFICATE OF DEATH.

90

D 83159

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 406 West 25th St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Spann

(a) Residence No. 406 West 25th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 21 1869

7-AGE, 54 yrs. 8 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Spann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Wards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Margaret Spann

(Address) 406 West 25th

15- JAN 23 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1923 to Jan. 26 1924

that I last saw her alive on Jan. 26, 1924

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Frank H. Bratton, M. D.

, 19 (Address) 4032 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL, Jan 30, 1924

20-UNDERTAKER Wm Cook — ADDRESS 501 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83160

CERTIFICATE OF DEATH.

159-002 D 83160

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 N. Chapple St., 6 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Angelio Mascelli

(a) Residence No. 229 N. Chapple St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 12/24

7-AGE. ....yrs. ....mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Guy Mascelli

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Madelmi

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Guy Mascelli
(Address) 229 N. Chapple

15- JAN 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/27/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 19 24 to Jan 27 19 24
that I last saw h[illegible] alive on Jan 26 19 24
and that death occurred, on the date stated above, at 6 [illegible] m.
The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) —
(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of.....
Was there an autopsy? No
What test confirmed diagnosis?.....

(Signed) John A. Fisch M.D.
Jan 28, 1924 (Address) 936 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer | DATE OF BURIAL. 1.28.1924

20-UNDERTAKER Philip Herweg | ADDRESS 2016 Aliceanna

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83161

CERTIFICATE OF DEATH.

71-D 83161

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Purcell

(a) RESIDENCE NO. 1808 Rutland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Purcell

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Metal worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Md

PARENTS

10 NAME OF FATHER Martin J Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Parkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 JAN 28 1924 ROBERT R. KRAUTER, Registrar. Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/22/24, 19..., to 1/28/24, 19..., that I last saw h— alive on 1/28/24, 19..., and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis (Pneumococcus).

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical Operation

(Signed) N. W. Kelly, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrest Hill Md.	Jan 30 1924

20 UNDERTAKER Ulmbrook ADDRESS 502 E North.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

83162

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. ~~Little~~ Sisters of the Poor St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Nash

(a) Residence No. Preston & Valley Sts. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Widower

6-~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Margaret O'Keefe

6-DATE OF BIRTH (month, day and year) 1834.

7-AGE. 90 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS:
10-NAME OF FATHER: William Nash
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Catherine McBride
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-
(Informant): Sister Superior
(Address): Preston & Valley Sts.

15-
Filed JAN 28 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): January 26/24

17- I HEREBY CERTIFY, That I attended deceased from No record 19.. to 19..
that I last saw h.. alive on July 24 19 24
and that death occurred, on the date stated above, at 2.20 P.M.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Patent adhesions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Jany 26 24 (Signed) Fall Warner M. D.
19 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan 28 1924
20-UNDERTAKER,	ADDRESS
D. E. Wadefield	719 Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83163

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D 83163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N. Mount ST., 19th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm J. O'Connor

(a) RESIDENCE No. 19 N. Mount ST., 19 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Scheier O'Connor

6 DATE OF BIRTH (month, day, and year) Aug 10, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Dublin Ireland

PARENTS

10 NAME OF FATHER Wm J. O'Connor

11 BIRTHPLACE OF FATHER (city or town) Dublin (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Connolly

13 BIRTHPLACE OF MOTHER (city or town) Dublin (State or country) Ireland.

14 Informant Mrs. Wm J. O'Connor 19 Mount St.

JAN 28 1924

Filed ..... 19 ..... ROBERT P. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1923 to Jan. 27, 1924.

that I last saw him alive on " 25, 1924,

and that death occurred, on the date stated above, at 3.15 A.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coolahan, M. D.

1/28 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	Jan 29 1924
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell.	W. Baltimore St.

Spec- 12-23-21—E.B.R.S.—400 Bks.

Shanty

HEALTH DEPARTMENT—CITY OF BALTIMORE

83164

CERTIFICATE OF DEATH.

D 83164

1-PLACE OF DEATH

City of BALTIMORE: (No. 615 S. Linwood Ave, 1 Ward) Registered No. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Shanty

(a) Residence No. 615 S. Linwood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 15, 1924

7-AGE X yrs. mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Ford

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER Thomas Shanty

11-BIRTHPLACE OF FATHER (city or town) Italy (State or Country),

12-MAIDEN NAME OF MOTHER Ruth Goldstein

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

11- (Informant) Thomas Shanty

(Address) 615 S. Linwood Ave

15- Filed JAN 28 1924 ROBERT R. KRAUS Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-27-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1924 to Jan 27 1924

that I last saw h. alive on Jan 26 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart Lesion — Failure

Edema of Pharynx

(Duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Burgdorf M. D

1-28 1924 (Address) 1001 N. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents Cemetery — DATE OF BURIAL. 1-28 1924

20-UNDERTAKER. George J. Ruth — ADDRESS 1735 Harford Ave

THIS IS A PERMANENT RECORD. Every item of information must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83165

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83165

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 ander ST.: 7 WARD)

2-FULL NAME Baby Lorhmann

(a) RESIDENCE. No. 1334 ander ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1.26.24

7 AGE — Years: 1 hour — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baelo md.

PARENTS

10 NAME OF FATHER Henry Lorhmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baelo. Md

12 MAIDEN NAME OF MOTHER Loda D. Gonzales

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton maryland

14 Informant Loda D. Gonzales (Address) 1324 ander st

15 Filed JAN 28 1924 . 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1.26.24 19

17 I HEREBY CERTIFY, That I attended deceased from 1.26.24 19 ... to 1.26.24 19 ..., that I last saw her alive on 1.26.24 19 ..., and that death occurred, on the date stated above, at 8.30P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (5½ months) Imature
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Morris, M. D.

1/27/24 (Address) 107 ½ west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: JAN 28 1924

20 UNDERTAKER ... ADDRESS ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

30

Corrected Feb 12 by W. D. Wells M.D.

Spec.—6-9-19—H. P. Co.—100M Blks.

D 83166

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 83166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Wm Hayes Funeral

CITY OF BALTIMORE: (No.) 5721 Dennison ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Washington

(a) RESIDENCE. No. 5721 Dennison ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. 5 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Aug 6/83

7 AGE: Years 5 Months 5 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nun

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Nun 5721 Dennison ave

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Maryland

12 MAIDEN NAME OF MOTHER: Alberta Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Alberta Washington
(Address) 5721 Dennison ave

15 [illegible] 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

JAN 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 19.., to Jan 23, 19 24

that I last saw h[illegible] alive on Jan 23, 19 24

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Probably, Pneumonia

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Wells, M. D.

19 (Address) 5242 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 29 1924

20 UNDERTAKER: James H. Dennis ADDRESS 1303 Preston

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); ***Measles;*** *Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchio-Pneumonia

ALL BUSINESS STRICTLY CASH AND PAYABLE AT THE TIME SERVICE IS RENDERED

REG. NO. 4432

DATE .....

DR. W. D. WELLS

PARK HEIGHTS & HAYWOOD AVES.

PHONE, LIBERTY 0091

HOURS: 10 TO 12 A.M. & 6 TO 8 P.M.

Feb 10 1924

PATIENT'S NAME .....

ADDRESS .....

R

Undertaker Dennis.

Pressman Dept. Gets Information for death Certificate from babys Mother & Gets it all wrong & he Misinformed the Doctor & Dr. Himself the next day

Alberta Gurney.
Baby-mother.

M. D.

E. G. ENGLINGER
RELIABLE PHARMACIST
PARK HEIGHTS & BELVIDERE AVES.
BALTIMORE
PHONE, FOREST 8950--8952

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83167

CERTIFICATE OF DEATH

100 D 83167

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 Park Ave ST. 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice V. Parker

(Residence in Baltimore: No. 865 Park Ave. St. 10 yrs. — mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White, Caucasian

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Mar (Month) 11 (Day) 1857 (Year)

7-AGE: 71 yrs. 9 mos. 16 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Home duties
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE (State or country): Prince Georges Co, Md.

PARENTS

10-NAME OF FATHER: John Parker

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Elizabeth Mosser

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Beulah F. Hemelwood

(Address) 865 Park ave

15- JAN 28 1924 Robert P. Harrison, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan (Month) 27 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 23, 1924, to Jan 27 1924, that I saw her alive on Jan 27 1924, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

acute Gastro Entro Colitis

(Duration) yrs 1 mos. 4 ds.

Contributory (SECONDARY) acute Bronchopneumonia

(Duration) 3 yrs. mos. 3 ds.

(Signed) D. H. Hildebrandt M. D.

Jan 28, 1924 [Address] 924 Eutaw St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Highland Md | DATE OF BURIAL: Jan 29 1924

20-UNDERTAKER: Geo. E. Enoch | ADDRESS: Laurel Md

D 83168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 83168

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 Druid St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth Ellis

(Residence in Baltimore: No. 1514 Druid St.; yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. X June 1923. (Month) (Day) (Year)

7-AGE. X yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). Gen'l

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Ellis

(Address) 1514 Druid Hill St

15- Robert P. Harrison, 192.....

FEB 2 1924 Burial Permit Clerk Registrar.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 27, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 4 ds.

(Signed) James M. Rowland M. D. (Coroner.)

Jan 27, 1924. (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Jan 29, 1924

20-UNDERTAKER, Brown & Sheeland — ADDRESS 1140 N

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83169

1-PLACE OF DEATH

City of BALTIMORE: (No. 1804 N Duke Lane St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Gustav Hornung

(a) Residence No. 1804 N Duke Lane St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male | 4-COLOR OR RACE, Wht | 5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Hornung

6-DATE OF BIRTH (month, day and year) July 19 1863

7-AGE, 60 yrs. 6 mos. 9 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)..... 013
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Germany
(State or Country),

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town)..... Ger.
(State or Country),

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town)..... Ger.
(State or Country),

14- (Informant) Mrs Louisa Hornung
(Address) 1804 N Duke Lane Ft

15- Robert F. Harrison,
Filed..... 192..... Burial Permit Clerk. Registrar.

JAN 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 28 24

17- I HEREBY CERTIFY, That I attended deceased from January 27th 24, to January 28th 24, that I last saw h.. alive on January 28th 24, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Contributory Valvular heart Dis. 20 Yrs known

(Duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward [illegible] M. D.

1/28, 192 (Address) 1605 N North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-~~PLACE OF BURIAL, CREMATION OR REMOVAL~~, Western (Emory) DATE OF BURIAL, 1/31, 1924

20-UNDERTAKER, Wm Cook ADDRESS 502 E 11th

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILMED

Spec.—1-10-21—M&T—1500 Bks.

D 83170

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 83170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Louis

(a) RESIDENCE NO. ~~Home~~ 1232 Ridgely ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1st 1922

7 AGE: Years 1 Months 1 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John M. Louis

11 BIRTHPLACE OF FATHER (city or town) France. (State or country)

12 MAIDEN NAME OF MOTHER Bessie Monchow

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant Records. (Address)

15 Robert P. Harrison, 19 ..... Registrar

JAN 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/28/1924.

17

I HEREBY CERTIFY, That I attended deceased from 11/28/24, 19..... to 11/28/24. 19.....

that I last saw h/ alive on 11:45a.m 11/27/1924,

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia (diffuse)

Malnutrition.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure.

terminal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home address.

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Yes.

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL Jan 29 1924

20 UNDERTAKER Wm Cook — ADDRESS 502E 40th

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S.A.

DAK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83171

CERTIFICATE OF DEATH.

1790 D 83171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 W. Mulberry St., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Wilhmina Marston

(a) RESIDENCE NO. 1909 W. Mulberry st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. Marston

6 DATE OF BIRTH (month, day, and year): Sept 7. 1865

7 AGE — Years: 58 — Months: 4 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Johnna Boos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. James H. Marston

(Address): 1909 W. Mulberry

15 FILED JAN 28 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26" , 1924 , to Jan 27" , 1924 , that I last saw her alive on Jan 27 , 1924 , and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Mitrial Regurgitation

(duration) 2 yrs. mos 27 ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Herbert E. Zepp, M. D.

Jan 28 1924 (Address) 3048 N. Yorke Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Jan 30 1924

20 UNDERTAKER: Jos Jacobsen Son — ADDRESS: 2473 Pac...

AN 28 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 1407 Cooksie St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Skerodowski

(a) Residence No. 1407 Cooksie St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6-DATE OF BIRTH (month, day and year) April 1864

7-AGE, 59 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), ~~Pole~~ Austria

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Europe

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Europe

14-

(Informant) Sophia Mieshaw

(Address) 1407 Cooksie St.

15-

Filed JAN 28 1924, 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 27. 1924

17- I HEREBY CERTIFY, That I attended deceased from 11-1-24, 19, to Jan 27 24, 19

that I last saw h[illegible] alive on Jan 25, 19 24

and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

1-28, 19 24 (Address) 1002 Hall Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Cross Cem. Co. DATE OF BURIAL, Jan. 30 1924

20-UNDERTAKER, Margaret A. Flynn ADDRESS 1422 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83173 D 83173

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4121 Parkheights ave. St. 15 Ward) 109

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Doris Adele Ruppert

(a) Residence No. 4121 Park Heights ave. St. ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 13. 1920

7-AGE, 3 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md

PARENTS.

10-NAME OF FATHER, Joseph A. Ruppert

11-BIRTHPLACE OF FATHER (city or town) Balto., (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mamie Alger

13-BIRTHPLACE OF MOTHER (city or town) Va. (State or Country),

14- (Informant) Joseph A. Ruppert (Address) 4121 Park Heights ave

15- Filed ..... Robert J. Harrison, Registrar.

N 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 25. 1924

17- I HEREBY CERTIFY, That I attended deceased from July 30— 1924 to Jan 25 1924 that I last saw ~~he~~ alive on July 31 1924 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Sepsis

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Gilbert Baker

(Duration) ....yrs. ....mos. 1 ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Blood

(Signed) A. Ruppert M. D.

, 19 (Address) 3 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Jan. 30 ..... 19 24

20-UNDERTAKER, Margaret L. Flynn ADDRESS 1422 Light St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83174

D 83174

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N Carrollton Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy E. Sales Soles

(a) RESIDENCE NO. Matthews Co, Va. ST., WARD Matthews Co. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Darsey S. Sales

6 DATE OF BIRTH (month, day, and year) May 5, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	~~7~~	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Co. Va.

PARENTS

10 NAME OF FATHER John R. Lamprin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Matthews Co Va.

12 MAIDEN NAME OF MOTHER Lucy C. Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middlesex Co Va.

14 Informant (Address) J. M Lamprin 826 N Carrollton Ave

15 Filed JAN 28 1924, 19 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1923, to Jan 28, 1924, that I last saw her alive on Jan 28, 1924, and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) and yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen. Carcinomatosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) J. M Lamprin, M. D.

, 19 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dover Point Dover

DATE OF BURIAL Jan 30 1924

20 UNDERTAKER Wm. Whitehouse

ADDRESS Walke

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every l... of ...or-mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... of certificates. PHYSICIAN ... should state ... Exact statement ... OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83175

CERTIFICATE OF DEATH.

90 D 83175

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Baker ST. 15 WARD)

2-FULL NAME Mary A. Templeton

(a) RESIDENCE No. 1809 Baker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
about 69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Lilly M Carter
(Address) 1805 Baker St.

15 Filed JAN 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1924, to Jan 26, 1924.

that I last saw her alive on Jan 26, 1924.

and that death occurred, on the date stated above, at 9. 45A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

Has had this condition several years. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ruptured compensation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? Physical examination of heart

(Signed) Chas A H Ashcraft, M. D.

19 (Address) 1307 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Jan 29 1924

20 UNDERTAKER Wm J. Pickett Sons — ADDRESS N & Pa

G INK—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 83176

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 83176

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 301 E. 29th St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Van Daniker

(a) Residence No. 301 E. 29th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie F. Van Daniker

6-DATE OF BIRTH (month, day and year) Aug 9. 1848

7-AGE. 75 yrs. 5 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Conrad Van Daniker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Switzerland

12-MAIDEN NAME OF MOTHER, Rebecca Hughes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dublin Ireland

11- Mrs. Charles Appel
(Informant)

(Address) 301 E. 29th St.

15- Robert F. Harrison.

19- Burial Permit Clerk.

JAN 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1924 to Jan 27 1924

that I last saw h[illegible] alive on Jan 26 1924

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Apoplexy, Hemiplegia

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Synmal Debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Stanley Gorman M. D.

Jan 27, 1924 (Address) 29 W. St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western — DATE OF BURIAL, Jan 29, 1924

20-UNDERTAKER, Isaac Cook — ADDRESS 1003 W. Baltimore St.

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83177

CERTIFICATE OF DEATH.

31 ✓ D 83177

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3040 St. Paul ..... St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Bessie E. Pearman .....

(a) Residence No. 3040 St. Paul ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Walter R. Pearman

6-DATE OF BIRTH (month, day and year) Feb. 15th 1900

7-AGE.	If LESS than 1 day,
23 yrs. 11 mos. 11 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ernest E. Agnew

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Kirby

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country), Maryland

14- (Informant) Ernest E. Agnew

(Address) 3040 St. Paul St.

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

JAN 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Jan 26 1924

that I last saw h[illegible] alive on Jan 26 1924

and that death occurred, on the date stated above, at 6.15 P.m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

1/28, 1924 (Signed) Wm. Miller, M. D.

(Address) 108 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
New Cathedral Cemetery	Jan 29, 1924
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gilmor St

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83178

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D 83178

D 83178

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

2-FULL NAME Rev. David F. O'Connor

(a) RESIDENCE No. Mt Hope Retreat ST. 28th WARD New York

(Usual place of abode) Abt

Length of residence in city or town where death occurred 13 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Dont Know mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Abt	57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman (Priest)

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work 018

(c) Name of employer

9 BIRTHPLACE (city or town) (?)
(State or country) Ireland

PARENTS

10 NAME OF FATHER Edmund O'Connor

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Anne Doyle

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Ireland.

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Retreat.

15- JAN 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 7th, 1911, to Jan 27th, 1924, that I last saw h[illegible] alive on Jan 27th, 1924, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Tuberculosis of Intestines.
(Preceded by Rectal Fistula)

Abt (duration) 10 mo 12 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Chr. Depr. Psychosis -

Abt (duration) 13 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? New York city

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Jan 29th, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City

DATE OF BURIAL Jan 28 1924

20 UNDERTAKER [illegible] & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 160

City of BALTIMORE: (No. 2408 E. Chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Kuc

(a) Residence No. 2408 E. Chase St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 31 1923

7-AGE.	If LESS than 1 day,
....yrs. ....mos. 28 ds.	....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) fd

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ignatius . Kuc

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Julia Wiek

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country),

14-

(Informant) Mr. Ignatius . Kuc

(Address) 2408 E. Chase Street

15-

Filed JAN 28 1924 19?

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 28/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 19 24 to Jan 28 19 24

that I last saw h.. alive on Jan 28 19 24

and that death occurred, on the date stated above, at 530 p. m.

The CAUSE OF DEATH* was as follows:

Inanition due
to Malnutrition

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Kyssanek M. D.

Jan 29 19 24 (Address) 80 N Kenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Jan. 30, 19 24
20-UNDERTAKER.	ADDRESS
John H. Weber	1803 Bank

No. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83180

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 838 Sharp St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie McBride

(a) Residence No. 838 Sharp St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col,

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Clifton McBride

6-DATE OF BIRTH (month, day and year) Mar 30 1889

7-AGE, 34 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer.....

9-BIRTHPLACE (City or town), (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Moore

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Md,

12-MAIDEN NAME OF MOTHER, Bernetta Barkley

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Md

11-(Informant) Bernetta Moore

(Address) 838 Sharp St

15-Filed ..... 192.. R. KRAUTER, Registrar.

JAN 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 26 '24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1923 to Jan 26, 1924, that I last saw h[illegible] alive on Jan 26, 1924, and that death occurred, on the date stated above, at 1.2 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) D. H. Connell, M. D.

1/28, 1924 (Address) 1400 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn — DATE OF BURIAL. Jan 29 1924

20-UNDERTAKER. John H Fowler — ADDRESS 142 Ostend St

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No 838 Sharp St., 22 Ward) Registered No. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mavis McBride

(a) Residence No. 838 Sharp St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 7 1917

7-AGE, 6 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Clifton McBride

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Lottie Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Bernetha Moore

(Address) 838 Sharp St

15-

Filed ....., 192.. ROBERT R. KRAUTER, Registrar.

JAN 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 26 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 1924, to Jan 26, 1924, that I last saw h[illegible] alive on Jan 26, 1924, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. H. Blackwell, M. D.

1/28, 1924 (Address) 1402 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL, Jan 29, 1924

20-UNDERTAKER John H. Jordan — ADDRESS 1412 Hill St

No. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83182

CERTIFICATE OF DEATH.

90 D 83182

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 15-28 n. Bruce ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Powell

(a) RESIDENCE. No. 15-28 n. Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. Powell

6 DATE OF BIRTH (month, day, and year) 3-20-66

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West River Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Roba Shaw

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Wm. F. Powell
(Address) 1040 n. Stricker St.

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27 — 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-29, 1927, to 1-27, 1924, that I last saw her alive on 1-18, 1924, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1700 n. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-28 1924
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83183

CERTIFICATE OF DEATH.

100-001 D 83183

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2920 Presstman St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Bermanzar

(a) Residence No. 2920 Presstman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph N. Bermanzar

6-DATE OF BIRTH (month, day and year) Jany 6. 1846

7-AGE. 78 yrs. mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Joseph Ritter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Bell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Hannah B. Shanetts

(Address) Catonsville Md

JAN 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk. John O. Mitchell 1201 W. Fayette St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jany 27. 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 21— 1924 to Jan 27th 1924 that I last saw her alive on Jany 27th 1924 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Dickson M. D

, 19 (Address) 3055 N. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge — DATE OF BURIAL. Jany 30 19 24

20-UNDERTAKER. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83184

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 224 N. Wolfe St., St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Martowitz

(a) Residence No. 224 N. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah -

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 72 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clothing

(b) General nature of Industry, business, or establishment in which employed (or employer) Tailor Shop

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) J. Lewis

(Address) 1439 E Baltimore St.

JAN 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 28-24

17- I HEREBY CERTIFY, That I attended deceased from Jan-23-, 1924 to Jan-28-, 1924

that I last saw h[illegible] alive on Jan-28- 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

-Cardio Renal disease-

Chronic Myocarditis

(Duration) about 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Seidel M. D.

Jan 28. 1924 (Address) 2404 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Fifth Row Cemetery — DATE OF BURIAL. Jan. 29.... 19.23

20-UNDERTAKER. Jos J. Lewis — ADDRESS 1439 E. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83185

100-001

D 83185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Longwood St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Richard Strow,

(a) RESIDENCE NO. 2115 Longwood St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. 4. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick R. Strow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Dorothy E. Griner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Frederick Read Strow,

(Address) 2115 Longwood St.

15 JAN 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1924, to Jan 29 1924.

that I last saw h[illegible] alive on Jan 28 1924,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 17 da. 11 days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Tibbett M. D.

(Address) 2220 Garrison Ave

Jan 29. 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan. 31 1924

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83186

CERTIFICATE OF DEATH.

X129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marine Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin a Murray

(a) RESIDENCE NO. U.S. Marine Hospital No1 ST., ... WARD Not Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 050

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer (U.S. Light H Service) Barge "Pine" D.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Self. Benja Murray (Address) U.S. Marine Hosp.

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to January 28 1924, that I last saw him alive on January 28, 1924, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Bronchopneumonia Lobar

Chronic Myocarditis.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. A. Foster M. D.

19 (Address) U.S. Marine Hospital

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1/31 1924
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 83187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1539 N. Broadway ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard J. Bloxham

(a) RESIDENCE. No. 1539 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza J. Field

6 DATE OF BIRTH (month, day, and year) Mar. 15 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	10	13	

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Birmingham
(State or country) England

PARENTS

10 NAME OF FATHER John Bloxham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Lloyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mrs. Eliza J. Bloxham
(Address) 1539 N. Broadway

15 Filed JAN 29 1924 16 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1923 to Jan. 28th 1924, that I last saw him alive on Jan. 27th 1924, and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 05 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? His condition

(Signed) J. B. Schwatka, M. D.

, 19 (Address) 710 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	1/30 '24

20 UNDERTAKER ADDRESS

Henry W. Mears & Son 805 Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83188

HEALTH DEPARTMENT—CITY OF BALTIMORE

146

D 83188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. St. Joseph's Hosp. ST., 8 WARD)

2-FULL NAME Bessie Cornelia Jenkins

(a) RESIDENCE No. 2206 E. Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (or) WIFE of: Cornelius L. Jenkins

6 DATE OF BIRTH (month, day, and year): Oct 5, 1901

7 AGE: Years 22 Months 3 Days 22 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED: At home

(a) Trade, profession or particular kind of work: 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward H. Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Virginia White

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto. Co, Md

14 Informant (Address): Cornelius L. Jenkins 2206 E. Biddle St

15 JAN 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1924 to Jan. 27, 1924, that I last saw her alive on Jan. 27, 1924, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis.

(duration) yrs. mos 8 da.

CONTRIBUTORY (Secondary): Lobar pneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S. & Lab.

(Signed) J. V. Szerlecki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Jan 30 1924

20 UNDERTAKER: Finkler & Finkler — ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 83189

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 N. Rose ST., 6 WARD)

2-FULL NAME Clara M. Wallace

(a) RESIDENCE NO. 238 N. Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27-1923

7 AGE: Years | Months: 5 | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Clyde Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys County

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys County

14 Informant (Address) Clyde Wallace 238 N. Rose St.

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-15, 1924, to 1-27, 1924, that I last saw h alive on 1-26, 1924, and that death occurred, on the date stated above, at 3 30 A

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(cons)

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Rumpf M. D.

(Address) 5001 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Jan 29 1924

20 UNDERTAKER: Chas E. Butler — ADDRESS: 1334 Jefferson St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Blks.

D 83190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 83190

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 N. Luzerne ST., 6 WARD)

2-FULL NAME Mary M. Franke

(a) RESIDENCE NO. 122 N. Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~: Mary M. Franke

6 DATE OF BIRTH (month, day, and year): Sept 24/85

7 AGE — Years: 38 Months: 4 Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md Annapolis

PARENTS

10 NAME OF FATHER: Frank M. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Louis D. Franke

(Address): 122 N. Luzerne Ave.

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1924

17

I HEREBY CERTIFY, That I attended deceased from June 21 1924 to June 27 1924, that I last saw her alive on June 27 1924, and that death occurred, on the date stated above, at 8 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Acute infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Harris, M. D.

June 27 1924 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 1/30/24

20 UNDERTAKER: Philip Herrig — ADDRESS: 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83191

CERTIFICATE OF DEATH.

90 D 83191

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2628 W^c Elderry St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Pasterfield

(a) Residence No. 2628 W^c Elderry St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND ~~of (or) WIFE~~ of: Nellie Pasterfield

6-DATE OF BIRTH (month, day and year): Nov 15/50

7-AGE. 73 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 062

(c) Name of employer: Novak Realty Co.

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Wm Pasterfield

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Martha —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-

(Informant): Nellie Pasterfield

(Address) 2628 W^c Elderry

15-

JAN 29 1924

ROBERT R. KRAUTER, City Clerk.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 1/26/24

I HEREBY CERTIFY, That I attended deceased from Dec 1923 to Jan 26 1924

that I last saw h/m alive on Jan 25 1924

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Contributory Duration: One yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration: yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cushing M. D.

Jan 27 1924 (Address) 3600 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Balto Cem.	1/29, 1924
20-UNDERTAKER.	ADDRESS.
Philip Herwig	2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83192

CERTIFICATE OF DEATH.

101-601

D 83192

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 N. Bethel ST., 8 WARD)

2-FULL NAME Marie E. Dressel

(a) RESIDENCE No. 1420 N. Bethel ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 30/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3 year.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Dressel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marie Ringler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant George F. Dressel
(Address) 1420 N. Bethel st.

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924, to Jan 29, 1924.

That I last saw him alive on Jan 29, 1924

and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis Incipt.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 1/31 1924

20 UNDERTAKER George J. Ruth

ADDRESS 1730 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83193

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Taylor ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Hampe.

(a) RESIDENCE (No. 2823 Taylor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Hampe

6 DATE OF BIRTH (month, day, and year): Dec. 17 1856

7 AGE: 67. (Years / Months / Days; If LESS than 1 day, ... hrs. or ..... min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Dietrich Bro

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John F. Hampe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: M. Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Ella Hampe

(Address): 2823 Taylor Ave

15 Filed JAN 29 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1923, to January 28, 1924,

that I last saw h— alive on January 27, 1924

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver,

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) J. H. Monroe, M. D.

(Address) 1214 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Jan. 31 1924

20 UNDERTAKER: Geo. J. Rutt

ADDRESS: 1305 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D~~ 83194

3 D 83194

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 Brighton ST. 16 WARD)

2-FULL NAME Mary Catherine Steinsieden

(a) RESIDENCE. No. 3005 Brighton ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 1901

7 AGE — Years: 22 — Months: — Days: 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lulu Hitchcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wm H Warfield
(Address) 3005 Brighton

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1923, to Jan. 27, 1924, that I last saw her alive on Jan 26, 1924, and that death occurred, on the date stated above, at 12 10 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms.

(Signed) Austin F. Robertson M. D.

1/28 1924 (Address) 1307 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 1/29/24

20 UNDERTAKER: E J Smith — ADDRESS: W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16159 83195

CERTIFICATE OF DEATH.

3 1 ✓ D 83195

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozetta Ruby Thomas

(a) RESIDENCE NO. 1516 Mullikin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June July 5 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
✓	3	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Wiley Thomas

11 BIRTHPLACE OF FATHER (city or town) D C

(State or country)

12 MAIDEN NAME OF MOTHER Thelia Brunson

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 3 —, 1924, to Jan 28, 1924

that I last saw her alive on Jan 28, 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thos. R Brown M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashburn Cemetery DATE OF BURIAL Jan 31 1924

20 UNDERTAKER Chas. H. Johnson 416 N. ADDRESS Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Conac)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83196

D 83196

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 Bradley St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annella Conac

(a) Residence No. 704 Bradley St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Washington Conac

6-DATE OF BIRTH (month, day and year) Feb. 6, 1868

7-AGE. 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. Jno. M. Dennison

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS:

10-NAME OF FATHER, Samuel J. Hudson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York

12-MAIDEN NAME OF MOTHER, Sarah Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Charles Co. Maryland

14- (Informant) Mrs. Sarah Marriott

(Address) 1546 Argyle Ave

15- Filed JAN 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 15, 1923 to Jan 27, 1924

that I last saw him alive on Jan 26, 1924

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John C. Cowley M. D.

, 19 (Address) 15 N. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Jan. 30, 1924
20-UNDERTAKER. Mrs. Katie R. Williams	ADDRESS 322 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83197

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 S 12th St., N Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rama Wingert

(a) Residence No. 616 S 12th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 9th 1924

7-AGE. ....yrs. ....mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, Ger Wengert

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country),

12-MAIDEN NAME OF MOTHER, Ada Weaver.

13-BIRTHPLACE OF MOTHER (city or town) Pa (State or Country),

14- (Informant) Ger Wengert

(Address) 616 S. 12th

15- Filed JAN 29 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 29/1924

I HEREBY CERTIFY, That I attended deceased from Jany 24 1924 to Jany 28 1924

that I last saw h. alive on Jany 28 1924

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

1/29 1924 (Address) 3307 E Balto St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL, Jan 30 1924

20-UNDERTAKER, John Lieser M.D. ADDRESS 200 N Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Frances Smith

D 83198

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316" Schroder St. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Smith

(a) RESIDENCE NO. 31 N Schroder ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1924

7 AGE: Years ..... Months ..... Days 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Thelma Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D C

14 Informant Stella Smith (Mother)

(Address) 316 N Schroder St

JAN 29 1924

Filed ..... 19 ..... Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 26, 1924.

That I last saw h alive on Jan 26, 1924,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W J Peck M. D.

, 19 (Address) 16 W Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

JAN 29 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

32

D 83199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83199

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 418 S. Calhoun St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Erney

(Residence in Baltimore: No. 418 S. Calhoun St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Mal	Wht	Marr

6-DATE OF BIRTH: Jan (Month) 15 (Day) 1847 (Year)

7-AGE: 77 yrs. 12 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Horse Painter

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Joseph Erney

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Abbott

(Address) 418 S Calhoun St

JAN 29 1924 (Filed) ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan (Month) 27 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Incipient Cirrhosis of Kidneys (Duration) 1 yrs. mos. ds.

(Signed) James M. Kershner M. D. (Coroner.)

Jan 27 1924 (Address) 700 E Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem	1/31/24

20-UNDERTAKER,	ADDRESS
George W Imley	Fulton & Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH CARBON BACK FOR DUPLICATE RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83200

D 83200

123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St. Agnes Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. A. Munk

(a) RESIDENCE NO. 514 N. Monroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Entire mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Anna Munk

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs Anna Munk

(Address) 514 N. Monroe St.

15 Filed JAN 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from June. 19, 1924, to June. 27, 1924, that I last saw him alive on June. 27, 1924, and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Pyosalpinx following Cholecystectomy.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Removal Gall Bladder

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 1/31 19 24

20 UNDERTAKER George A. Fuhrman — ADDRESS Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83201

CERTIFICATE OF DEATH.

11-002

D 83201

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5011 Beauregard Ave., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Virginia Parker

(a) Residence No. 5011 Beauregard Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Cld.	Sngle

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 1, 1923

7-AGE.	If LESS than 1 day.
....yrs. 10 mos. 26 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9-BIRTHPLACE (city or town) (State or Country), Same Balto Md

PARENTS.

10-NAME OF FATHER, Statham B. Parker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cockeysville Md

12-MAIDEN NAME OF MOTHER, Elsie Graham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Frederick Co Md

14- (Informant) Father S B Parker

(Address) 5011 Beauregard Ave

15- Filed JAN 29 1924 ROBERT H. KRAUTER, Vital Records Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 26 1924

17- I HEREBY CERTIFY, That I attended deceased from January 10, 19 24 to January 26, 19 24

that I last saw her alive on January 26, 19 24

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Urinalysis

(Signed) D. H. Bishop M. D.

Jan 27, 1924 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Rough Chapel Cemetery	Jan 29 1924
20-UNDERTAKER.	ADDRESS
Lehar & Alexander	526 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is required. See instructions on back of certificates.

...ATES STANDARD ...E OF DEATH.

...aus and American Public Health Asso.]

...of Occupation.—Precise statement of ...n is very important, so that the relative ...ulness of various pursuits can be known. ...e question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Influenza

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83202

CERTIFICATE OF DEATH.

90 D 83202

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 McElderry St ST., 5 WARD)

2-FULL NAME Frank. Bailey (Baylor)

(a) RESIDENCE NO 1219 McElderry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 45 or 46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Effie Johnson
(Address) 1219 McElderry St.

15 Filed ..... 192 JAN 29 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ..... yrs. ..... mos. 14 ds.

(Signed) J. S. H. Fallin, M. D.
(Coroner.)

Jan 29, 1924 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Jan 29 1924
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83203

CERTIFICATE OF DEATH.

31 D 83203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Green

(a) RESIDENCE NO. 515 W. Biddle st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 years Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 JAN 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1924, to Jan. 25, 1924, that I last saw her alive on Jan. 25, 1924, and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) [signature] M. D.

1-25-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 29 1924
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1725 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAKO

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148 D 83204

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Kelley

(a) RESIDENCE NO. Cumberland Road. ST., WARD Cumberland Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katharine Kelley

6 DATE OF BIRTH (month, day, and year): July 24 1860

7 AGE: Years 57 Months 6 Days If LESS than 1 day.....hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vale Summit Md

PARENTS

10 NAME OF FATHER: Anthony Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm. E. Kelley

(Address) 2632 E. Baltimore St.

15 JAN 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-28 1924

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923, to Jan 28, 1924, that I last saw h i alive on Jan 28, 1924, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of Neck - Fran

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 30

Was there an autopsy? No

What test confirmed diagnosis? U.S.S. + Autopsy

(Signed) H. E. Cuddy, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md — DATE OF BURIAL: Jan 31 1924

20 UNDERTAKER: Jos. A. Kern & Son — ADDRESS: 156 N. Luzerne

Spec.—6-9-19—H. P. Co.—1000 Blks.

Sims

HEALTH DEPARTMENT—CITY OF BALTIMORE

83205.

CERTIFICATE OF DEATH.

101-001 ✓ D 83205

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Cathedral ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Gertrude Sims.

(a) RESIDENCE. No. 1045 Cathedral ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin F. Sims

6 DATE OF BIRTH (month, day, and year) April. 10. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caterress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William A. Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Emily Greene

13 BIRTHPLACE OF MOTHER (city or town) Easton Talbot
(State or country) Maryland

14 Informant Elizabeth E. Bradford
(Address) 1047 Cathedral St

15 Filed ..... 19 ..... Registrar

JAN 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1924, to Jan 27, 1924, that I last saw h.. alive on January 27, 1924, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright M. D.

1/28, 1924 (Address) 1709 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	1/30/24 19

20 UNDERTAKER George T. A. Gibson ADDRESS 1738 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83206

CERTIFICATE OF DEATH.

100-001 ✓

D 83206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A. Klunk

(a) RESIDENCE NO. 519 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Sixteen mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary MacCubbin

6 DATE OF BIRTH (month, day and year): Aug 12 1830

7 AGE — Years: 93 — Months: 5 — Days: 15 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unkn.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hospital

JAN 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1924, to Jan 27, 1924, that I last saw him alive on Jan. 27, 1924, and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Psychosis with arter. Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. F. Dorsett, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem — DATE OF BURIAL: 1/30/24

20 UNDERTAKER: Gorgell Funeral Parlors — ADDRESS: Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83207 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 83207

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 102 E. Madison St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Roddy

(a) Residence No. 102 E. Madison St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Roddy

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE,	If LESS than 1 day,
62 yrs. -- mos. -- ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Peter Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Coffay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Miss May Roddy
(Address) 102 E. Madison Street

15-

Filed JAN 29 1924 192.. ROBERT R. KRAUTH
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Jan 27, 1924

that I last saw her alive on Jan 27, 1924

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 10 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Greene M. D.

1-28-1924 (Address) 120 Augusta Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral Cemetery	1/30, 1924

20-UNDERTAKER,	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 83208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83208

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Warner ST.: 21 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No name Inf of Virgil & Lula Reynolds

(Residence in Baltimore: No. 628 Warner St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Col	

6-DATE OF BIRTH, Jan (Month) 27 (Day), 1924 (Year)

7-AGE, ...yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland,

PARENTS.

10-NAME OF FATHER, Virgil Reynolds

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Lula Brown

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virgil Reynolds

(Address) 628 Warner St.

15- Filed JAN 29 1924, 191.. ROBERT R. KRAUTER, Registrar of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1924, to Jan 27 1924, that I saw h[illegible] on Jan 27 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Born alive but died 5 or 10 Later Caused by Coma Unable to secure Physician in time

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary).....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

1-28, 1924 (Address) 706 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Jan 28, 1924

20-UNDERTAKER Geo Scott Hooper ADDRESS 706 N. Eutaw St

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D 83209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83209

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Forrest St. ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Kehoe

(a) RESIDENCE NO. 706 Forrest St. ST., WARD

(Usual place of abode) 50

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine T. Kehoe

6 DATE OF BIRTH (month, day, and year): Unknown 1854

7 AGE: Years 70 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Policeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Kehoe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Sinnott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine T. Kehoe

(Address): 706 Forrest St.

Date: JAN 29 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 26th. 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1923, to Jan 26, 1924

that I last saw him alive on Jan 26, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Peck M. D.

Jan 28. 1924 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery.

DATE OF BURIAL: Jan. 30" 24

20 UNDERTAKER: Chas. F. Cranston & Son

ADDRESS: 1180 N. Royal ave

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.E.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83210 D 83210

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 1119 Hull St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Clark.

(a) Residence No. 1119 Hull St., 24 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Clark.

6-DATE OF BIRTH (month, day and year) Aug. 17. 1842

7-AGE. 82 yrs. 5 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 674

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Loader.

(c) Name of employer Self.

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Anna Clark

(Address) 1117 Hull St.

15- Robert P. Marriott,

Filed JAN 29 1924 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 28-24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 19 23 to Jan 28 19 24

that I last saw him alive on Jan 28 19 24

and that death occurred, on the date stated above, at 10 45a m.

The CAUSE OF DEATH* was as follows:

Marasmus Senilis.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis at Atelectasis

(Duration) yrs. 3 mos. 28 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens, M. D.

1/28. 1924 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	1/30, 19 24
20-UNDERTAKER. J. Wesley Mears	ADDRESS 1318 Eight Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Boesch

(a) Residence No..... Austria St., Ward South America

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-~~Single,~~ Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Angelina Boesch

6-DATE OF BIRTH (month, day and year) —— 1887

7-AGE 36 yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or ...min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do not know

14-(Informant) Mrs. Broeck

(Address) Austria

15-...Jan 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 28, 1924

17-I HEREBY CERTIFY, That I attended deceased from Jan. 22 19 24 to Jan. 28 19 24

that I last saw him alive on Jan. 28 19 24

and that death occurred, on the date stated above, at 12 45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ...yrs. ...mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? South America

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S. Goldman M. D

19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL, 1/30, 19 24

20-UNDERTAKER J. Valley Howe — ADDRESS 1318 Light St.

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83212 ✓ D 83212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Parrish ST., Market Smith - 16 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Market Smith -

(a) RESIDENCE NO. 905 Parrish ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18-97

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chas. A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Catherine Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Catherine Smith
(Address) 905 N. Parrish

15 Robert P. Harrison, Registrar
Burial Permit Clerk

JAN 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/15 1924, to 1/27 1924,
that I last saw h[illegible] alive on 1/27 1924,
and that death occurred, on the date stated above, at 12 30 P m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia -

(duration) yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 0 0 0

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Burkett M. D.

1924 (Address) 2139 D-A-9

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 30 1924

20 UNDERTAKER: Sam'l R. Chase & Son — ADDRESS: 1402 Mosher

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83213

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Reimer

(a) RESIDENCE NO. 128 Albion Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Schmidt

6 DATE OF BIRTH (month, day, and year) July 17 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Reimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Oppenheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Reimer (Wife)

(Address) 128 Albion Ave

15 Filed JAN 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1924, to Jan 27, 1924, that I last saw him alive on Jan 27, 1924, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Uncertain ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 24, 1924

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & operation.

(Signed) A B Price, M. D.

(Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Jan 31st 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 4038 Mary

Cor.—1-12-23—M&T—100 Bks.

D 83214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83214

CERTIFICATE OF DEATH.

172

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 26 WARD)

2-FULL NAME Mary C. Nelson

(a) RESIDENCE NO 1527 S. Clinton ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Nelson

6 DATE OF BIRTH (month, day, and year) Nov. 12/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael F. Finnerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Dunnington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Michael Finnerty
(Address) 1527 S. Clinton St

15 Filed JAN 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull - Jumped from window at St. Joseph Hospital

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Insanity

..... (Duration) probably a few hrs

(Signed) ..... (Coroner.), M. D.

Jan 29/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Park.	Jan 31st 1924
20 UNDERTAKER Lilly & Feiler	ADDRESS 138 N. Howard St.

FILL OUT WITH UNFADING INK. TYPEWRITE IF POSSIBLE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83215

CERTIFICATE OF DEATH.

111-001

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Mrs Pauline Williams

(a) RESIDENCE No. 1502 W. Lexington ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Charles Williams.

6 DATE OF BIRTH (month, day, and year) Apr 7, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Newburg N.Y.

PARENTS

10 NAME OF FATHER Matthews Austerpaint

11 BIRTHPLACE OF FATHER (city or town) (State or country) Albany, N.Y.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles Williams

(Address) 1502 W. Lexington St

15 Filed ..... 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

JAN 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 28, 1924, that I last saw her alive on Jan 28, 1924 and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastric ulcer & Acute Nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 26th 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) [redacted], M. D.

, 19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL Jan 30, 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 - C Ross

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83216

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 83216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1616 w Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Wilma M. Hurley

(a) Residence No. 1616 w Lanvale St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 3, 1900

7-AGE, 24 yrs. 26 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Baker

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry McHarlup

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Margaretta M. Kirby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant)..... Harry Edward Hurley

(Address)..... 1616 W Lanvale St

15- Filed ..... Robert F. Harrison, Registrar.

N 2 91924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-29-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 st, 1923, to Jan 29, 1924, that I last saw alive on Jan 28, 1924, and that death occurred, on the date stated above, at 1.40 PM

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pyelitis

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ray O'Sullivan, M. D.

1-29-24, 19 (Address) 1616 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Feb 1, 1924

20-UNDERTAKER Wm Oliver ADDRESS 507 E Monument

FILL IN—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE [illegible] in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83217

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal tuberculosis Hospital ST., 8 WARD)

2-FULL NAME John Kuberth

(a) RESIDENCE NO. 1200 N. Bradford st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Kuberth

6 DATE OF BIRTH (month, day, and year) June 6, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pressman 063

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Kuberth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Dorbert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Hospital Records
(Address) M.T.H.

15 Filed ..... 19 ..... Robert F. Harrison, Registrar
Burial Permit Clerk.

JAN 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1920, to Jan. 28, 1924.

that I last saw him alive on Jan. 28, 1924,

and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Kelly, M. D.

1-29-24 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Jan 30, 1924
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83218

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Colonial Hosp.

CITY OF BALTIMORE: (No. 1124 N. Monroe ST., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Aiken

(a) RESIDENCE No. 923 S. 2nd St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ? 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Joshua Aiken (dead)

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Melva (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Sister — Mrs. Lily Kenly

(Address) 323 N. Second st.

15 Filed ....., 19 Robert P. Harrison, Registrar

JAN 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/3 ....., 1923, to Jan. 29, 1924.

that I last saw him alive on Jan. 28, 1924

and that death occurred, on the date stated above, at 8.20 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis

8 (?)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

several years

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Wasserman

(Signed) A. A. Swoszman, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia S. C.

DATE OF BURIAL Jan 31 1924

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1225 Parkland

Spec.—1-10-21—M&T—1500 Blks.

D 83219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 14 WARD)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Young

(a) RESIDENCE NO. 706 Madison St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Wm Young

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mercy Hospital (Address)

15 Robert F. Harrison, Registrar

JAN 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27/24

17 I HEREBY CERTIFY, That I attended deceased from 1/26/24, 19..., to 1/27/24, 19..., that I last saw h— alive on 1/27/24, 19...; and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 1/26/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Jan 30 1924
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1720 Cashland

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83220

CERTIFICATE OF DEATH.

31

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S and official state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Altoona ave. ST. 27 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Thomas Toal

(a) RESIDENCE No. 112 Altoona ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26 1894

7 AGE — Years: 30 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): auto agency
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER Thos. Toal

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER Mary Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant Thos. Toal
(Address) 112 E. Altoona ave

15 Filed JAN 29 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 7, 1924, to Jany 25, 1924, that I last saw him alive on Jany 25, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

1/29 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — DATE OF BURIAL 1/30/ 1924

UNDERTAKER J. A Moran — ADDRESS 3006 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

(Minnie Book) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83221

CERTIFICATE OF DEATH.

90

D 83221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 W. Lee St. ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Book

(a) RESIDENCE NO. 126 W. Lee St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Book

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel H. Book

(Address) 206 E. Baltimore St.

15 Filed ..... 19 .....

Robert F. ... Registrar

Burial Permit Clerk

JAN 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 19 24

17

I HEREBY CERTIFY, That I attended deceased from January 29, 1924, to January 29, 1924, that I last saw her alive on January 29, 1924, and that death occurred, on the date stated above, at 12 45 M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ... yrs. ... mos. now ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. H. Smith M. D.

Jan 29, 1924 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Road	1/29 1924
20 UNDERTAKER	ADDRESS
A. Lipson + Bro	E. Balto St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CHRISTIAN NAME is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83222 | CERTIFICATE OF DEATH. | 129 | D 83222

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No 1935 Penrose ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Margaret Virginia Snead

(Residence in Baltimore: No. 1935 Penrose Ave St.; 35 yrs., 1 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May 8, 1853 (Month) (Day) (Year)

7-AGE, 70 yrs. 8 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Perry Knight

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Mary Ellen Bird

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F. L. Bonneville

(Address) 638 E. 81st Cleveland Ohio

15- JAN 29 1924 Robert F. Harrison, ..., 191.....
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 27, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1923, to Jan 27th 1924, that I saw h[illegible] alive on Jan 27th 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

Superinduced by Chronic Nephritis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(Duration) Unknown yrs. mos. ds.

(Signed) William Dew M. D.

Jan 28, 1924 (Address) 1742 Moreland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, February 1, 1924

20-UNDERTAKER George J Smith — ADDRESS 153 Hollins st

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(1) 83223 (1) 83223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 Lehus Square ST., 22nd WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Jenkins

(a) RESIDENCE NO. 214 Lehus Square ST., Carroll Co. WARD Sparks Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto County Glencoe.

PARENTS

10 NAME OF FATHER: Clarence Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Lucille Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Glencoe

14 Informant: Lucille Jenkins (Address): mother

15 Filed JAN 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 29 1924 19

17

I HEREBY CERTIFY, That I attended deceased from 1/27, 1923, to 1/29, 1924, that I last saw her alive on 1/28, 1924, and that death occurred, on the date stated above, at 9:35 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): probable Varicella

(duration) indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. L. Jackson M. D.

19 (Address) 618 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevenson Chapel	Jan 30 1924
20 UNDERTAKER	ADDRESS
Wm G Brooks	Sparks Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83224

CERTIFICATE OF DEATH.

5 185

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Harry Wagner

(Residence in Baltimore: No. 117 E Fayette St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Divorced

6-DATE OF BIRTH. Nov 2 1888
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
35 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Bartender
(b) General nature of industry, business, or establishment in which employed (or employer). Bar

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Hugh Wagner

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Katie Ginter

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Wagner

(Address) 1030 Patapsco Street

15- Filed ..... 192.... Robert P. Harrison, Burial Permit Clerk. Registrar.

A N 2 91924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 25 192.4
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot wound of head caused by accidentally falling down stairs at home.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

1-29 192.4 (Address) 1535 E Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cem

DATE OF BURIAL. Jan 30 192.4

20-UNDERTAKER. Robt B. Cost

ADDRESS 1003 N Gilmor St

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83225

CERTIFICATE OF DEATH.

48 D 83225

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 319 S. Gilmor St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis A. Peddicord

(a) Residence No. 319 S. Gilmor St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada Peddicord

6-DATE OF BIRTH (month, day and year): Jan. 26, 1896

7-AGE: 28 yrs. 0 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Gauge Tester

(b) General nature of industry, business, or establishment in which employed (or employer): Kilburn

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Elkridge, Maryland

PARENTS.

10-NAME OF FATHER: Stephen B. Peddicord

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Elkridge, Maryland

12-MAIDEN NAME OF MOTHER: Rachel L. Mercer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14- (Informant): Mrs. Ada Peddicord

(Address): 319 S. Gilmor Street

15- Filed 19 Registrar.

JAN 29 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): January 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 10 — 1923 to January 28 1924

that I last saw him alive on January 28 1924

and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Head

Gangrene (Duration) 1 yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) St Clair W Kennard M. D.

1-29, 1924 (Address) 705 Ensor Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Jan 31, 1924

20-UNDERTAKER: Joseph L. Cook

ADDRESS: 1003 W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 83226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83226

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S. Furrow ST., 20 WARD)

2-FULL NAME Eliza June Green

(a) RESIDENCE NO. 324 S. Furrow ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Henry Green

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) New York

PARENTS

10 NAME OF FATHER George B. Barrett

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Radley

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) New York

14 Informant George H. Green
(Address) 324 S. Furrow Street

15 JAN 29 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 27, 1924, that I last saw h[illegible] alive on Jan 26, 1924, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Hemiplegia)
Cerebral Hemorrhage
Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis Chronic
Pericarditis (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert C Thiel M. D.

1/29 1924 (Address) 2157 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan. 30 1924

20 UNDERTAKER: Jos B Cook — ADDRESS: 1003 N Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83227

CERTIFICATE OF DEATH.

46 D 83227

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 W. Pratt St ST. 19 WARD)

2-FULL NAME Myrtle E. Ford

(a) RESIDENCE NO. 1413 W. Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Samuel A. Green

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Gumpenon

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country) Md

14 Informant Samuel A. Green (Address) 509 Richwood Ave

15 Filed JAN 29 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27/1924

17

I HEREBY CERTIFY, That I attended deceased from 3/31/1923, to 1/27/1924,

that I last saw her alive on 1/27/1924, 19....,

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Mar. 1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic.

(Signed) [illegible], M. D.

1/27/1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Jan 30 1924

20 UNDERTAKER Harry H. Goltz & Co — ADDRESS 1531 W. Lombard St

MARGIN RESERVED FOR BINDING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83228

CERTIFICATE OF DEATH.

7 X 100-001

D 83228

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.**

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Jesse Ryan

(a) RESIDENCE NO. Mt Airy Md ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred: ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mt. Airy (State or country) Md.

PARENTS

10 NAME OF FATHER Jesse Ryan

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Murray

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 13- 1924 to Jan 29- 1924

that I last saw him alive on Jan 29- 1924,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis Indigestion

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) (a) Vacuum Otis Nyasa 2 mo.

(b) Acute Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bagg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Chapel Cem. Howard Co. Md.

DATE OF BURIAL 1-29 1924

20 UNDERTAKER E & B Harle

ADDRESS 115 E West St

Spec.—8-24-14—M. & T.—2000 Bks.

D 83229

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-007 83229

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 W. Hamburg ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Stella Di Blasi

(Residence in Baltimore: No. 119 W. Hamburg St.; 10 yrs. 5 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fem

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) widow

6-DATE OF BIRTH. March (Month) 18 (Day), 1870 (Year)

7-AGE. 83 yrs. 10 mos. 10 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. John Greco

11-BIRTHPLACE OF FATHER (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Sophia Ladelfa

13-BIRTHPLACE OF MOTHER (State or Country). Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D. Blasi

(Address) 119 W. Hamburg

15. JAN 30 1924, 191... ROBERT R. KRAUTEN, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 28 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 1924, to Jan 28 1924, that I saw her alive on Jan 28 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic cranitis

..... (Duration) ..... yrs. 1 mos. 12 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 5 yrs. ..... mos. ..... da.

(Signed) Chas. Testa M. D.

....., 191... (Address) 110 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State .....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Vincent's Dom

DATE OF BURIAL. 1/30/24 191...

20-UNDERTAKER Geo J Pudy

ADDRESS 1735 Hanford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83230

CERTIFICATE OF DEATH.

11-001

D 83230

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Green Hillow ST., 17 WARD)

2-FULL NAME Clifton Brown

(a) RESIDENCE NO. 524 Green Hillow ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 3 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Butts,
(State or country)

PARENTS

10 NAME OF FATHER Russell Brown

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Chatman

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Alice Brown
(Address) 524 Greenwillow St

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1924, to Jan. 27, 1924,

that I last saw him alive on Jan. 26, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lagrippe

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James M Harper, M. D.

1/28, 1924 (Address) 513 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	1/30/24

20 UNDERTAKER Samuel L Kennedy & Bro

ADDRESS 1911 E Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 523 14 509

D 83231

83231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514½ Gilmor St. 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Wooden

(a) RESIDENCE NO. 514½ Gilmor ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Joseph Wooden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Pulling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Wooden (Address) 514½ Gilmor St.

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 20, 1924, to Jany 28, 1924, that I last saw her alive on Jany 27, 1924 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam.

(Signed) David Wagner M. D.

Jany 29, 1924 (Address) 1176 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Jan 31 1924

20 UNDERTAKER Leonard E. Wright — ADDRESS 364 W. Cary

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83232

CERTIFICATE OF DEATH.

167-021

D 83232

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 24 WARD)

2-FULL NAME August E. Witte.

(a) RESIDENCE NO 40 E. Fort Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 12, 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cigar maker.
(b) General nature of industry, business, or establishment in which employed (or employer): 017
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Frederick C. Witte.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Caroline L. Vordemberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Kauderer. (sister) (Address) 40 E. Fort Ave.

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas Asphyxia.
Suicide.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jan, 29, 1924 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 40 E. Fort Ave. Jan. 25, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan 29 1924

20 UNDERTAKER: H. Howard Evans — ADDRESS: 1428 N. Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83233

CERTIFICATE OF DEATH.

179 D 83233

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N. Arlington Ave ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Schuster

(a) RESIDENCE NO. 526 N. Arlington ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? 69 yrs. 6 mos. 18 ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Elizabeth Catherine Schuster

6 DATE OF BIRTH (month, day, and year): July 10 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant. 045

(b) General nature of industry, business, or establishment in which employed (or employer): Bed. Mfgr.

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Schuster

11 BIRTHPLACE OF FATHER (city or town) (State or country): ??? Germany

12 MAIDEN NAME OF MOTHER: Dorothea Nordt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ??? Germany

14 Informant: Geo. J. & Chas. J. Schuster (Sons)
(Address) 526 N. Arlington Ave

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar

JAN 3 01924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to Jan 28, 1924, that I last saw h[illegible] alive on Jan 27, 1924, and that death occurred, on the date stated above, at 5.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Cardiac Decompensation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary & Physical

(Signed) [illegible], M. D.

(Address) 719 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Jan 30 1924

20 UNDERTAKER: [illegible] MOWEN COMPANY, WILLIAM F. WOODEN, Successor — ADDRESS: 109 W. [illegible]

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83234

CERTIFICATE OF DEATH.

74-001 D 83234

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 914 E. Lombard ST., 3 WARD)

2-FULL NAME Sarah Levin

(a) RESIDENCE NO. 914 E Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 37
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Julius Levin
(Address) 914 E. Lombard St

15 Filed JAN 30 1924, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)
Jan 29th, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Jan 30 1924
20 UNDERTAKER Jack Levin	ADDRESS 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 83235 HEALTH DEPARTMENT—CITY OF BALTIMORE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

D 83235
REGISTERED NO. C 6 90

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2574 McCulloh st ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lipman Silverman

(Residence in Baltimore: No. 1804 E. Fayette st St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	white	Widower

6-DATE OF BIRTH, ... Unknown (Month) ..... (Day) ....., 18.. (Year)

7-AGE, ... 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... L. Levin

(Address) ..... 1397 E. Baltimore

15- JAN 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 29th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1924, to Jan 29 1924, that I saw h in alive on Jan 29 1924, and that death occurred, on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonic tuberculosis

(Duration) 6+ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute dilatation of the heart

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benjamin Posner M. D.

Jan 30..., 1924 (Address) 1304 Eutaw pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Wash Road	Jan. 30..., 1924
20-UNDERTAKER Jack Levin	ADDRESS 1397 E. Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83236
Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 3152 Fredrick Ave St., 20 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hom Hopf.

(a) Residence No. 3152 Fredrick Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer): 041
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ohio

PARENTS.
10-NAME OF FATHER, Hom Hopf
11-BIRTHPLACE OF FATHER (city or town) (State or Country).
12-MAIDEN NAME OF MOTHER,
13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Hom Hopf
(Address) 209 W Mulberry St.

15- Filed ..... 192 ..... ROBERT P. KRAUTER Registrar.

JAN 30 1924 Board Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 1924 to Jan 27 1924
that I last saw her alive on Jan 27 1924
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Arteria Sclerosis

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Angina pectoris
(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History & Findings
(Signed) Duncan P Ralagio M D
, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Jan 30. 1924
20-UNDERTAKER, John O. Mitchell ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 D 83237

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Meyer

(a) RESIDENCE NO 101 Hare St. North ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Meyer

6 DATE OF BIRTH (month, day, and year) June 16,1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	7	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Storekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Groceries & Notions

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Endrees

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Daughter
(Address) 101 N. Hare St

15 Filed JAN 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd & 3rd degree burns -back, arm & thighs. Accidental - clothes caught from gas stove.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Weller, M. D. (Coroner.)

Jan 30/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Jan. 31, 1924
20 UNDERTAKER	ADDRESS
H. Sander + Sons	1710 Eutaw St.

U.S.A. • KELLY

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 83238

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 83238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4607 Eastern Ave ST. 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Romelis

(a) RESIDENCE. No. 4607 Eastern Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
X	1	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Romelis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Greece

12 MAIDEN NAME OF MOTHER Rita Bolitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece

14 Informant Rita Romelis
(Address) 4607 Eastern Ave

15 JAN 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 28 1924

17

I HEREBY CERTIFY, That I attended deceased from 1 27, 1924, to 1 28, 1924, that I last saw h... alive on 1 28 1924, and that death occurred, on the date stated above, at 5 7 m.

The CAUSE OF DEATH* was as follows:

Auto Dissection
acc Pulm Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion Abrasion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1924 (Address) 2617 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 30 1924
20 UNDERTAKER	ADDRESS
H. Gander & Sons	710 Fleet St.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83239

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 S. East Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard H. Dashiell

(a) Residence No. 918 S. East Ave St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Dashiell

6-DATE OF BIRTH (month, day and year) Dec 21, 1846

7-AGE. 77 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) Can Factory
(c) Name of employer..... Continental Can Co.

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Dashiell

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ann Asher

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland

14-

(Informant) Sarah E. Dashiell

(Address) 918 S. East Ave

15-

Filed..... 192.. ROBERT S. KRAUTER, Registrar.

JAN 30 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 28. 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1923 to Jan 28 1924

that I last saw h. alive on Jan 26 1924

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm H McAvoy M. D

1/29 1924 (Address) 839 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cemetery — DATE OF BURIAL. Jan. 31 1924

20-UNDERTAKER. H. Vander & Sons — ADDRESS 1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83240

CERTIFICATE OF DEATH.

100-001

D 83240

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2216 Cambridge St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred W. Gabrielsen

(a) Residence No. 2216 Cambridge St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 1-1923

7-AGE: ...yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Gustav Gabrielsen

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Norway

12-MAIDEN NAME OF MOTHER: Amelia Koserske

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) Mrs. Amelia Gabrielson

(Address) 2216 Cambridge St.

15-

Filed JAN 31 1924 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 29, 1924

I HEREBY CERTIFY, That I attended deceased from January 28th 1924 to January 29th 1924

that I last saw him alive on January 28th 1924

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ...yrs. ...mos. 2 ds.

CONTRIBUTORY (Secondary): Convulsion

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amelia E. Fuck M. D

19 (Address) 1717 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Pauls Cemetery	Jan. 31, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander & Sons	1710 Fleet St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83241

D 83241

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1908 Fleet St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Szymaurka

(a) Residence No. 1908 Fleet St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 25 mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-[illegible], Married, ~~Widowed~~, ~~or Divorced~~, (~~[illegible]~~ word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pete Szymanska

6-DATE OF BIRTH (month, day and year) Feb 2 - 1859

7-AGE 65 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Pete Szymanska

(Address) 1908 Fleet St

15- JAN 3 01924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 28-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924 to Jan 28, 1924

that I last saw her alive on Jan 28 1924

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? unknown

(Signed) John A. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Cross	Jan 31, 19 24
20-UNDERTAKER, F. W. Gazuski	ADDRESS 1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73 D 83242

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 13 S. Curley St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladystawa Durmowicz —

(a) Residence No. 13 S Curley St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, ~~Married, Widowed, or Divorced,~~ (~~Write the word.~~) Sngl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) DEC-15-1900-

7-AGE. 23 yrs. 1 mos. 14 ds. If LESS than 1 day, ✓ hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cigar maker

(b) General nature of Industry, business, or establishment in which employed (or employer) American Tob. Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. City —

PARENTS.

10-NAME OF FATHER. Casteni Durmowicz

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Poland.

12-MAIDEN NAME OF MOTHER. Antonia Kowalska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Poland

14- (Informant) Antoni Durmowicz

(Address) 13 S Curley St

15-

Filed ..... 192 ..... Registrar.

JAN 30 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan - 29-24

17- I HEREBY CERTIFY, That I attended deceased from Oct - 24 — 1923 to Jan 29 — 1924

that I last saw h. alive on Jan 29 — 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pancreas Myeletis —

Cause unknown - Duret Hem-

morrhage - due to Hemorrhage

with Sp. Cord — (Duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary) Sepsis - following bedsore —

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Max E Bossler M. D.

, 19 (Address) 1257 Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary | DATE OF BURIAL, Jan 31 24, 19..

20-UNDERTAKER. F W Ozazunk | ADDRES 1930 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 83243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 N Rose ST., 8 WARD)

2-FULL NAME George Tatem

(a) RESIDENCE NO. 1502 N. Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Tatem

6 DATE OF BIRTH (month, day, and year) July 5 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Thomas Kelly (Address) 1502 N Rose

15 JAN 3 01924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan 29, 1924

that I last saw him alive on Jan 25, 1924

and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Indefinite

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Finding

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cemetery	1924
20 UNDERTAKER Wendell Oppelt & Son	ADDRESS 373 Lenmt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83244

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83244

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1005 Hillen St ..... St., 5 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Freidlander

(a) Residence No. 1005 Hillen St ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Max Freidlander

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE. 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER, Julius Cohen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 E Balt St

15-

Filed JAN 30 1924 192

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan 29/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1923, to Dec 26, 1923, that I last saw her alive on Dec 26, 1923, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Chronic
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic
(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Epstein M. D.

, 19 (Address) 1904 E Balt St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Kehlen Woodlawn

DATE OF BURIAL, 1924: Jan 30

20-UNDERTAKER: Jack Lewis 1439

ADDRESS: E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 83245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1295 83245

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Rachel A. Koller

(Residence in Baltimore: No. Home for the aged of the M. E. Church St.; 81 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Feb 9 (Month) (Day) 1844 (Year)

7-AGE, 79 yrs. 11 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Abraham Wamer

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Susanna Turnbaugh

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Ella E. Addy

(Address) 400 N. Fulton Ave.

15-

Filed JAN 30 1924 193.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 29 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 23 1924, to Jany 29 1924, that I saw her alive on Jany 28 1924, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Hepatitis Chronic

(Duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 2 yrs. ✓ mos. ✓ ds.

(Signed) George C. Shannon M. D.

1/29, 1924 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, Jan 31, 1924

20-UNDERTAKER Jas J Smith & Son — ADDRESS Holbrook

N. B.—Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spencer

D 83246 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 D 83246

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 N. Fulton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 16.)

2-FULL NAME Elizabeth Spencer

(Residence in Baltimore: No. 5 N. Fulton St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	Widow

6-DATE OF BIRTH. ..... (Month) (Day) 1853 (Year)

7-AGE.	If LESS than 1 day,
71 yrs. ..... mos. ..... ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER, (State or Country). " "

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Easton

(Address) 916 Eutaw

JAN 3 0 1924

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... (Month) Jan 26 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to.. her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Don't Know (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Bruenech M. D.
(Coroner.)

1924 (Address) 129 W. Baltimore

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	1-30 1924
20-UNDERTAKER.	ADDRESS
Daniel Easton	916 Eutaw Cem

Spec.—1-10-21—M&T—1500 Bks.

D 83247 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 83247

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST., 27 WARD)

2-FULL NAME Emily Katherine Rieman

(a) RESIDENCE NO. 419 Lake Ave., ST., WARD Govans. Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Rieman

6 DATE OF BIRTH (month, day, and year) Mar. 30 1851

7 AGE	72 Years	9 Months	28 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) on a U.S. boat near China

PARENTS

10 NAME OF FATHER Francis W. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Ann Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs L. Francis
(Address) 422 Lake Ave

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Jan 29, 1924.

that I last saw h alive on Jan. 29, 1924

and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Arteritis & Paral-
yrs Agitans (duration) 3.0 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lay Martin, M. D.

Jan 29. 1924 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 31 1924
20 UNDERTAKER Henry W Jenkins Sons Co	ADDRESS Orchard & Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 83248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 83248

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1844 Light ST., 23 WARD)

2-FULL NAME Joseph McLaughlin

(a) RESIDENCE No. 1844 Light ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James P. McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary M. McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs M. McLaughlin (Address) 1844 Light St.

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1924, to Jan 29, 1924, that I last saw h alive on Jan 29, 1924, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Cyanosis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R E Campbell M. D.

1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Jan 30 1924
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1442 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—REGISTERED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

83249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83249

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 625 South 13th St Highlandtown 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Virginia Smith

(a) Residence No. 625 South 13th St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Grover C. Smith

6-DATE OF BIRTH (month, day and year) Feb. 22, 1886.

7-AGE. 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of indnstry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS.

10-NAME OF FATHER, James Samuel Reynolds

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary E. Tomlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Mr. Grover C. Smith

(Address) 625 South 13th St Highlandtown

15- JAN 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/29/24

17- I HEREBY CERTIFY, That I attended deceased from 1/25, 1924 to 1/29, 1924

that I last saw h.. alive on 1/29, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

60 hrs

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Reifschneider M. D.

1/30, 1924 (Address) 2939 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Richmond Va

DATE OF BURIAL. Jan 31 1924

20-UNDERTAKER. Wm Cook

ADDRESS North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Chr. Interstitial Nephritis

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83250

CERTIFICATE OF DEATH.

1625 D 83250

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Baby Armstrong

(a) RESIDENCE No. 1635 McElderry ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan. 12 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Dora Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed JAN 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924, to Jan 27, 1924, that I last saw her alive on Jan 27, 1924 and that death occurred, on the date stated above, at 6 00 a.m.

The CAUSE OF DEATH* was as follows:

Atelectasis. Congenital

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E Edmunds, M. D.

1/27, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 30, 1924

20 UNDERTAKER .....

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—REGISTERED FOR BINDING

34

Spec.—1-10-21—M&T—1500 Bks.

D 83251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/4 D 83251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp 4 St. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Seaman (Grant Zeman)

(a) RESIDENCE No. 204 Gay st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Seaman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M.T.H.

15 JAN 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1923, to Jan. 29, 1924, that I last saw him alive on Jan. 29, 1924, and that death occurred, on the date stated above, at 12.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally, M. D.

1-29-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Lookout	Jan 31 1924
20 UNDERTAKER	ADDRESS
Frank Ewell & Son	Baltimore.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83252

118-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST. No WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Stubacky Stefanofsky

(a) RESIDENCE No. 400 S. 13th ST.. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Stefanofsky

6 DATE OF BIRTH (month, day, and year) March 4 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Slavakia

PARENTS

10 NAME OF FATHER Center Maritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Slavakia

12 MAIDEN NAME OF MOTHER Helen Gabriz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Slavakia

14 Informant Frank Maritz

(Address) 400 S. 13th St.

15 JAN 30 1924 ROBERT R. KRAUTER Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1924. to Jan. 29, 1924.

that I last saw her alive on Jan. 29, 1924,

and that death occurred, on the date stated above, at 1.10 p. m.

The CAUSE OF DEATH* was as follows:

Postoperative Shock

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diaphragmatic hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of Jan. 28, 1924

Was there an autopsy? no

What test confirmed diagnosis? X-ray + operation

(Signed) Howard M. Kaufman M. D.

. 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 1 1924
20 UNDERTAKER	ADDRESS
Frank Creel Son	1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83253

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Ashland Ave ST., 10 WARD)

2-FULL NAME Charles P. Gemmecker Sr.

(a) RESIDENCE No. 1305 Ashland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Chas P. Gemmecker Jr.
(Address) 1305 Ashland Ave

15 JAN 3 01924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1920 to Jan 28 1924

that I last saw h... alive on Jan 26 1924

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. P. Fuchs, M. D.

Jan 30, 1924 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 31 1924
20 UNDERTAKER	**ADDRESS**
Frank A. Fink	915 N Gay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83254

CERTIFICATE OF DEATH.

57 D 83254

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1306 John St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Morris

(a) Residence No. 1306 John St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of -------

6-DATE OF BIRTH (month, day and year) Nov. 2, 1859

7-AGE. 64 yrs. 2 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Assistant Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Dorman's Pharmacy 27

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: William Morris

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Julia McDonnel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Mrs. Mary E. Bates
(Address) 1520 Caroline St, Wash. D.C

15- JAN 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Jan. 29-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 10 — 1924 to Jan. 29 — 1924 that I last saw her alive on January 21 — 1924, and that death occurred, on the date stated above, at 7 42 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Unknown (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Urinary

(Signed) Edwin B. Fenby M. D

1/30/1924 (Address) 1223 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	1/31 1924
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83255

CERTIFICATE OF DEATH.

161-901 D 83255

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 426 N. Bond St., 6 Ward)

(If death occurred in hospital or institution give its NAME instead of street and number.)

2-FULL NAME. Baby Byrd

(a) Residence No. 426 N. Bond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Jan 29 - 1924

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 6 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... tramp

(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Orie Byrd

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Ethel Price

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Virginia

11- (Informant) Orie Byrd

(Address) 426 N. Bond St

15- JAN 30 1924 19.. ROBERT R. KRAUTER, Registrar.

Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 29 - 192

17- I HEREBY CERTIFY, That I attended deceased from

On Jan 29 1924 to ..... 19.....

that I last saw him alive on Jan 29 1924,

and that death occurred, on the date stated above, at 5.30 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. E. Thomas, M. D

1-30, 1924 (Address) 822 N. Bond St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL — DATE OF BURIAL .....

20-UNDERTAKER, Commissioner Health, — ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83256

CERTIFICATE OF DEATH.

47 D 83256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 E. Lafayette Ave ST., 12 WARD)

2-FULL NAME Mary M. Wright

(a) RESIDENCE No. 327 E. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Wright

6 DATE OF BIRTH (month, day, and year) Nov 25-1879

7 AGE	Years	Months	Days	If LESS than 1 day... hrs. or ... min.
	44	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Thomas Storey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Timmons

13 BIRTHPLACE OF MOTHER (city or town) W. Virginia (State or country)

14 Informant Mrs John Ingram (Address) 1424 Augusta St

15 Filed JAN 30 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 16th, 1923, to Jany 28th, 1924, that I last saw her alive on Jany 28th, 1924, and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. Profound mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jany 6 1924

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) Eldridge, M. D.

19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 1/31 1924

20 UNDERTAKER Chas. B. Kraus & Son

ADDRESS 118 N. Howard

Rev

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 83257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D 83257

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dickinson

(a) RESIDENCE No. Scotland Neck N.C. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lillian Dickinson

6 DATE OF BIRTH (month, day, and year) July 12 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lockhaven Pa

PARENTS

10 NAME OF FATHER Wm C. Dickinson

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Manchester Eng

12 MAIDEN NAME OF MOTHER Mary Flynn

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Gloucester, Belgium

14 Informant (Address) JOHNS HOPKINS HOSPITAL

JAN 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 17- 1923, to Jan 29- 1924,

that I last saw him alive on Jan 29- 1924,

and that death occurred, on the date stated above, at 7 16 P- m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder with

General carcinomatosis

(duration) yrs. mos 4 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-17-23 11-22-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral Cemetery	Jan 31 1924
20 UNDERTAKER	ADDRESS
Geo M. Zink & Son	811 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Meany

Spec.—1-10-21—M&T—1500 Bks.

D 83258

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-08, 83258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wm. E. Douglass St., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 226 N. Wolfe St

(a) RESIDENCE No. 226 N. Wolfe St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or WIFE of) Annie Douglass

6 DATE OF BIRTH (month, day, and year) Dec. 28th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain (Oyster Boat

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wicomico Co. Md

PARENTS

10 NAME OF FATHER ????? Douglass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wicomico Co. Md

12 MAIDEN NAME OF MOTHER ?????? White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wicomico Co. Md.

14 Informant Annie Douglass (Address) 226 N. Wolfe St.

15 JAN 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29-1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1924, to Jan 29, 1924, that I last saw h[illegible] alive on Jan 29, 19..., and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. S. Hommeston, M. D.

1/30, 1924 (Address) 733 Ag South St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 1/31/24,

20 UNDERTAKER H. E. Hughes 424 N Broadway. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83259

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Linden Ave 14 WARD)

2-FULL NAME Elizabeth Neumann

(a) RESIDENCE NO. 1523 Linden av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Neumann

6 DATE OF BIRTH (month, day, and year) Feb 21 1847

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. J. Neumann

(Address) 1523 Linden Ave

15 Filed JAN 30 1924 . 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 24 , 1924 , to Jan 28 , 1924 .

that I last saw h[er] alive on Jan 27 , 1924 ,

and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Chas J Bloss , M. D.

Jan 29 1924 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 31 1924
20 UNDERTAKER	ADDRESS
H C Wiedefeld	917 Greenmount

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 83260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Vniversity Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Vogel

(a) RESIDENCE NO. Reisterstown Va ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	sing.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Conrad Vogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital. Vniversity

(Address) Lombard & Green Sts.

JAN 3 01924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1924, to Jan 29, 1924, that I last saw him alive on Jan 29, 1924, and that death occurred, on the date stated above, at 2.30 Pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with generalized metastasis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & X ray

(Signed) W Wallace Walker, M. D.

, 19 (Address) Vniversity Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Md

DATE OF BURIAL Jan 30 1924

20 UNDERTAKER Harry H. Wetzler

ADDRESS 1531 W Lombard St Balto. Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83261

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-08 D 83261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. ~~701 W. Lexington~~ ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Winternitz

(a) RESIDENCE. No. ~~Franklin Square Hospital~~ 701 W. Lexington St WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Weil

6 DATE OF BIRTH (month, day, and year) Unknown 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk Dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER David Winternitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Adele Frankenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant David Winternitz (Address) 1001 W Fayette St

15 [illegible] Robert P. Harrison, Registrar

AN3 01924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1924, to Jan 30th 1924, that I last saw him alive on Jan 30th 1924, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Rusty Sputum

(Signed) T Kenneth Williams, M. D.

, 19 (Address) 601 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harsina Cemetery	Feb 1 1924
20 UNDERTAKER	ADDRESS
J Ahrens & Co	1611 Mad Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 Piedmont Road St., West Hamilton WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara C. James

(a) RESIDENCE No. 123 Piedmont Road St., West Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. James

6 DATE OF BIRTH (month, day, and year) March 1st 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Joseph Coale

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Watson

13 BIRTHPLACE OF MOTHER (city or town) Bail Co. (State or country) Maryland

14 Informant Miss Phebe James (Address) 123 Piedmont Road Hamilton

15 Robert P. Harrison, Registrar

JAN 30 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 11, 1924. to Jany 29, 1924. that I last saw her alive on Jany 28, 1924. and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Infirmities of Age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

1/30. 1924 (Address) Hamilton Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camp Chapel Cemetery — DATE OF BURIAL Jan 31 1924

20 UNDERTAKER Fredk Lassahn & Sons — ADDRESS Fullerton

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83263

CERTIFICATE OF DEATH.

90

D 83263

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital ST., 8 WARD)

2-FULL NAME Anna Gough

(a) RESIDENCE NO. 1108 N. Paca ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years 48 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Md

PARENTS

10 NAME OF FATHER Joseph Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Matthews (Address) 1st Point St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

AN 30 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-1924

17 I HEREBY CERTIFY, That I attended deceased from 1-9-, 1924, to 1-27-, 1924,

that I last saw her alive on 1-27-, 1924

and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of Heart

Mitral Insufficiency

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? own

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. D. Purnell, M. D.

1-27, 1924 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cadbery Cemetery — DATE OF BURIAL: Jan 31 1924

20 UNDERTAKER: R E Small — ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No History.

Spec.—1-10-21—M&T—1500 Blks.

1 L D 25
83264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 131 D 83264

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.**

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gould

(a) RESIDENCE NO. 917 Kirby Place. Shreve Port, Louisiana
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Calbert Gould

6 DATE OF BIRTH (month, day, and year) Dec 25 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ky

PARENTS

10 NAME OF FATHER John E. Gould

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Lou Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 JAN 30 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 17, 1923 to Jan 29, 1924.

that I last saw h alive on Jan 29, 1924

and that death occurred, on the date stated above, at 11.42 P.M.

The CAUSE OF DEATH* was as follows:

Paraplegia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? town

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shreveport La	Feb. 1 1924

20 UNDERTAKER	ADDRESS
Stewart & Women Co.	108 W. North Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 83265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced dead at University Hospital Registered No. C.....

City of BALTIMORE: (No. 511 Washington Boulevard St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Beel York

(Residence in Baltimore: No. 15-45-Yr. Port of N. W. Washington D.C. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colo	Mar

6-DATE OF BIRTH, ... (Month) ..... (Day) 88 (Year)

7-AGE	If LESS than 1 day,
36 yrs. ..... mos. ..... ds.	....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Sidney Minor

11-BIRTHPLACE OF FATHER, (State or Country), Va,

12-MAIDEN NAME OF MOTHER, Anna Murray

13-BIRTHPLACE OF MOTHER, (State or Country), Va,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Brooks

(Address) 52 d Pleasant St

15- Robert P. Harrison, 192.... Registrar.

Burial Permit Clerk.

AN3 01924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) June 28 (Day) ....., 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:* Fractured Skull.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Struck from Automobile a few miles

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

1-30 192.4 (Address) ..... U.S.V. Sanatorium

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Washington D.C. DATE OF BURIAL, Jan 30 1924

20-UNDERTAKER, Saml D Hensley ADDRESS 515 N Eutaw

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.-1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83266

CERTIFICATE OF DEATH.

30 D 83266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2925 Cedar Ave ST., 13 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josie A Sharrer

(a) RESIDENCE No. 2925 Cedar Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph C Sharrer

6 DATE OF BIRTH (month, day, and year) July 23 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jermiah Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Joseph C Sharrer 2926 Cedar Ave

15 ....., 19 Robert F. Harrison Registrar

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 30 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1924, to Jan 29, 1924.

that I last saw her alive on Jan 27, 1924

and that death occurred, on the date stated above, at 230 A m.

The CAUSE OF DEATH* was as follows:

Mycosis Fungoides

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) 3 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Biopsy

(Signed) Leon Gusberg, M. D.

Ja 29 1924 (Address) 1906 Wilkens av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Jan 31 1924

20 UNDERTAKER CRENOWETH & SON, ADDRESS 2617 CRESCENT AVE

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 83267

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2814 Dillon St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edwin H. Curry

(a) Residence No. 2814 Dillon St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. 1 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) Jan 2nd 72

7-AGE, — yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) Inland

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore City Md.

PARENTS.

10-NAME OF FATHER, Howard Curry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore City Md.

12-MAIDEN NAME OF MOTHER, Matilda Marshall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore City Md.

14-(Informant) Howard Curry

(Address) 2814 Dillon St

15-

JAN 3 1924

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 30 - 24

17- I HEREBY CERTIFY, That I attended deceased from Jan ....., 1924, to Jan 30, 1924, that I last saw him alive on Jan 28, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pemphigus neonatorum

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. W. Wright, M. D.

Jan 30, 1924 (Address) 1014 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Carmel DATE OF BURIAL, Jan 31, 1924

20-UNDERTAKER, Peter Nicolaus ADDRESS 2060 Eastern Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(John Bitter)

D 83268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83268

1-PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 10 WARD)

2-FULL NAME John Bitter

(a) RESIDENCE NO. 925 ST. Harford Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years 57 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cork cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Cork

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John S Bitter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hester A Fiasa.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs Mary A Bruff

(Address) 2018 E Preston St

JAN 30 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to Jan 30, 1924

that I last saw him alive on Jan 30, 1924

and that death occurred, on the date stated above, at 8.55A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Schumich M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 1 1924

20 UNDERTAKER Wm Cook — ADDRESS 502E Pratt

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Spec.—1-10-21—M&T—1500 Bks.

D 83206 16426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 83269

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 11

CITY OF BALTIMORE: (No. ..... WARD)

2-FULL NAME William F Schepler

(a) RESIDENCE No. 204 W Monument St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Schepler

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) " 066

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ....., 19 Robert B. Marriott, Registrar

Burial Permit Clerk.

JAN 30 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1924, to Jan 30, 1924, that I last saw him alive on Jan 30, 1924, and that death occurred, on the date stated above, at 5-9 m.

The CAUSE OF DEATH* was as follows:

Syphilis, myocardial insufficiency, aortic insufficiency -

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema & infarcts

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 1 1924
20 UNDERTAKER Wm. Cook	ADDRESS 503 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83270

CERTIFICATE OF DEATH.

38 D 83270

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Donnelly

(a) RESIDENCE NO. 732 Hartford Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Gladys Donnelly

6 DATE OF BIRTH (month, day, and year) May 1, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0440

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1923, to Jan. 28, 1924, that I last saw him alive on Jan. 28, 1924, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (terminal)

..... (duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Syphilis Paralysis Luetic infection

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy findings

(Signed) N. Edmonds, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 1, 1924
20 UNDERTAKER	ADDRESS
Wm Cook Son & Co	[illegible]

AN3 D1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83271

D 83271

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....

CITY OF BALTIMORE: (NO. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Fitzpatrick

(a) RESIDENCE No. 1507 W. Mulberry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced (or) ~~WIFE of~~ Kate T Fitzpatrick

6 DATE OF BIRTH (month, day, and year) Unknown 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85			

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work ~~Laborer~~

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland Do

12 MAIDEN NAME OF MOTHER ~~New York~~ Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

JAN 30 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1924, to Jan. 28, 1924, that I last saw him alive on Jan. 28, 1924, and that death occurred, on the date stated above, at 6.35 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical Typhoid

What test confirmed diagnosis? .....

(Signed) J. T. Thomas, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL Feb 1, 1924

20 UNDERTAKER Wm. Cook — ADDRESS 507 E. North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83272 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1930 Hollins St., 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry S. Brown

(Residence in Baltimore: No. 1930 Hollins St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feb (Month) 3 (Day) 1862 (Year)

7-AGE, 61 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrical
(b) General nature of industry, business, or establishment in which employed (or employer): Worker

9-BIRTHPLACE, (State or Country): Salt Lake City,

PARENTS.

10-NAME OF FATHER, Wm. K. Brown

11-BIRTHPLACE OF FATHER, (State or Country), Penn.

12-MAIDEN NAME OF MOTHER, Virginia Saylor

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora B. Lamp

(Address) 1930 Hollins St

15- Robert F. Harrison, 192.. Registrar.

JAN 3 01924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 29 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry,) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy at home

Duration 1 hr

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W. Fenton M. D. (Coroner)

Jan 30 1924. (Address) 702 E. Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	Feb 2, 1924
20-UNDERTAKER, Wm. Cook	ADDRESS 502 E. Chase

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 83273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hosp. for the Women of Maryland ST. ..... WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Dorothy Kriel

(a) RESIDENCE No. 4401 Main Ave. ST., West Forest Park WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles G. Kriel, Jr.

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER John William Kratz

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) City

12 MAIDEN NAME OF MOTHER Miss Bockelman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md

14 Informant Chas. G. Kriel

Address 4401 Main ave, Forest Park

15 Filed JAN 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 29, 1924, that I last saw her alive on Jan. 29, 1924, and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease

(duration) 1 yrs. 6 mos ——— ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) E. Sutton Gorls, M. D.

1-29. 1924 (Address) Women Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Jan 31 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Heart
No other history

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83274

CERTIFICATE OF DEATH.

X 57 D 83274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. The Cambridge Apartments. WARD) 5th St

2-FULL NAME Mary Rollins Averell

(a) RESIDENCE NO. The Cambridge Apts ST. 5th St. WARD Resident St Louis Missouri

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jno H Averell

6 DATE OF BIRTH (month, day, and year) Oct 10th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Columbia (State or country) Missouri

PARENTS

10 NAME OF FATHER James S. Rollins

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Hickman

13 BIRTHPLACE OF MOTHER (city or town) Columbia (State or country) Missouri

14 Informant Sydney R. Averell (Address) St Louis Mo.

15 JAN 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 1924, to Jan 29th 1924, that I last saw her alive on Jan 29th 1924, and that death occurred, on the date stated above, at 5 Pm m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of urine & blood

(Signed) Thos. R. Boggs, M. D.

, 19 (Address) 1013 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia Mo. DATE OF BURIAL Jan 31 1924

20 UNDERTAKER Chas. G. Black ADDRESS 742 W Fayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Protosewicz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83275

CERTIFICATE OF DEATH.

118-002

D 83275

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Essex ST., 1 WARD)

2-FULL NAME Antoni protosewicz

(a) RESIDENCE No. 2210 Essex ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19-1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) " " ditto

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Protosewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephin Rudnicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Protosewicz.

(Address) 2210 Essex St

15 JAN 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1924, to Jan 29, 1924, that I last saw her alive on Jan 29, 1924, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) .. yrs. .. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) .. yrs. .. mos. .. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ryan, M. D.

19 (Address) 20 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	Jan 30 1924
UNDERTAKER	ADDRESS
Wm Garkowski	1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83276

CERTIFICATE OF DEATH.

124 D 83276

REGISTERED NO.....

(If death occurred in a hospital or institution give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Druid Hill Ave ST.: 14 WARD)

2-FULL NAME Ursula R Stewart.

(a) RESIDENCE. No. 1908 Druid Hill Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington, Va.

PARENTS

10 NAME OF FATHER Robert Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Hodgett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lexington, Va

14 Informant Lucy Stewart Mother
(Address) 1908 Druid Hill Ave.

15 JAN 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/23/ 1924, to 1/28/ 1924, that I last saw her alive on 1/28/ 1924, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Colombo Carcinoblastoma

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hartman M. D.

1/28/, 1924 (Address) 912 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 31 1924

20 UNDERTAKER Samuel H. Ensley
ADDRESS 1 Gaddis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83277.

CERTIFICATE OF DEATH.

57 D 83277.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Gold St., ST., 15 WARD)

2-FULL NAME Charles L. Bailey

(a) RESIDENCE NO. 508 Gold ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Alfred J. Bailey

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie E. Lane

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary B Adams
(Address) 508 Gold St

15 Filed JAN 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to Jan. 28, 1924, that I last saw him alive on Jan. 27, 1924, and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes.

..... (duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis acute

..... (duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Fehling -

(Signed) James M Halpin, M. D.

1/28 1924 (Address) 513 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 1/31 1924

20 UNDERTAKER Samuel Hamsley

ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D83278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2117 E Chase St 8 179

REGISTERED NO.

CITY OF BALTIMORE: (No. 2117 E. Chase ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eliza Frances Fisher

(a) RESIDENCE NO. 2117 E Chase St ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: William H Fisher deceased

6 DATE OF BIRTH (month, day, and year): Jan. 5. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co.

PARENTS

10 NAME OF FATHER: Cornelius Jarrelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Fisher (son)

(Address): 2117 E Chase St

JAN 3 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 13 1923 (own) to Jan. 28, 1924, that I last saw her alive on Jan. 28, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Paranchymatous Nephritis

(duration) yrs. 3 mos. 17 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis

(duration) yrs. 3 mos. 17 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Woodward, M. D.

Jan 28, 1924 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U.S. National

DATE OF BURIAL: 1/31 1924

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

83279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83279

CERTIFICATE OF DEATH.

1565-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Flora Cochran

(a) Residence No. 3502 Copley Road St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single,~~ Married, ~~Widowed,~~ or ~~Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Clarence Cochran

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), do

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), do

14-INFORMANT (Informant) Clarence Cochran

(Address) 3502 Copley Road

15-JAN 31 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 30-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 25, 1923, to Jan 30, 1924, that I last saw h[illegible] alive on Jan 30, 1924, and that death occurred, on the date stated above, at 6.50 m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukaemia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Blood Picture

(Signed) I. Goldman M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy | DATE OF BURIAL Feb 1, 1924

20-UNDERTAKER Henry W Meyer & Son | ADDRESS 805 N Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83280

CERTIFICATE OF DEATH.

161-001

D 83280

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. Sharp Street ST.; 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claudia White

(a) RESIDENCE. No. 711 S. Sharp Street ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 26 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter White

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Lena Worrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lena White

(Address) 711 Sharp St

Filed JAN 31 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1924, to Jan 30 1924,

that I last saw her alive on Jan 30 1924,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Physical Condition of Mother

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Bronner M. D.

, 1924 (Address) 712 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Jan 31 1924
20 UNDERTAKER	ADDRESS
J. D. Brown & Son	108 W. Monte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 83281 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH. D 83281

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 521 Archer St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick J. Allen

(a) Residence No. 321 archer St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 10 1923

7-AGE, ...yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jerry Allen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Alexander Va

12-MAIDEN NAME OF MOTHER, Bessie Reed

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New castel Del

14- (Informant) Mrs Jerry Allen

(Address) 521 Archer St

15- Filed JAN 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 30/24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 29 1924, to Jan 30 1924, that I last saw him alive on Jan 30, 1924, and that death occurred, on the date stated above, at 1036 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Worthington M. D.

1/31, 1924 (Address) 2 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Feb 1, 1924

20-UNDERTAKER.	ADDRESS
Johnson & Sons	1803 Bank

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83282

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S. Montford Ave. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julijanna Schultz

(a) RESIDENCE NO. 710 S Montford Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34. yrs. mos. ds. How long in U. S., If of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Schultz,

6 DATE OF BIRTH (month, day, and year) Dec. 26. 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	I	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work, 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Rosie Slowinowski.

(Address) 710 S. Montford Ave

15 Filed JAN 3 1924 ROBERT P. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1923, to Jan 30, 1924,

that I last saw her alive on " 29, 1924,

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Meer, M. D.

1/31/24 (Address) 4088 Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem., DATE OF BURIAL Feb. 2nd. 1924.

20 UNDERTAKER M. J. Sadowski. ADDRESS 705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 83283

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Stanford Place ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry E. Talley

(a) RESIDENCE NO. 514 Stanford Place ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Cd.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza S. Talley

6 DATE OF BIRTH (month, day, and year): Aug 31 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	53	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): O T O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Alexander Talley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Jane Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: James Talley (Address) 514 Stanford Street

15 JAN 3 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 30th 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany 23 1924 to Jany 30th 1924, that I last saw h[e] alive on Jany 29th 1924, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Hemorrhage Gradual

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) ..... M. D.

. 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemy	2/1/24

20 UNDERTAKER George T. A. Gibson ADDRESS 1735 Druid Hill Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83284

CERTIFICATE OF DEATH.

129 D 83284

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N. Bond ST., 6 WARD)

2-FULL NAME Peter Kelly

(a) RESIDENCE NO. 300 N. Bond ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: Col. | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant William Brunson (Address) 836 George St.

15 JAN 31 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1924 to Jan. 25, 1924, that I last saw him alive on Jan. 25, 1924, and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

1/25, 1924 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Jan 31 1924

20 UNDERTAKER Chas. H. Johnson & Co. — ADDRESS 1100 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83285

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Miller ST., 7 WARD)

2-FULL NAME Albert Keeley

(a) RESIDENCE NO. 1606 Miller ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Gertrude Keeley

6 DATE OF BIRTH (month, day, and year) May 23, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Robert H. Keeley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary B. Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Gertrude Keeley wife

(Address) 1606 Miller St.

15 Filed JAN 31 1924 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 28, 1924, that I last saw him alive on Jan 28, 1924, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical & Lab.

(Signed) R J Conley, M. D.

1/31 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Jan 31 1924
20 UNDERTAKER Mrs. P. C. Elliott	ADDRESS 1226 Eastland

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83286

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 220 b Ashland St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka Louise Beverungen

(a) Residence No. 220 b Ashland St., ... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 16th 1859

7-AGE. 64 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER John Beverungen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Augusta Stanman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) John G. Beverungen

(Address) 220 b Ashland Ave.

15- Filed JAN 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 28/1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 11, 1923, to January 28, 1924, that I last saw h.. alive on January 28, 1924 and that death occurred, on the date stated above, at 1150 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Pulmonary

Oedema

(Duration) ....yrs. 5 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted If not at place of death? —

Did an operation precede death? n. Date of .....

Was there an autopsy? n.

What test confirmed diagnosis? Clinical

(Signed) D. E. Carman, M. D.

1-30-, 1924 (Address) 1701 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19....
Greenly Odonnal &	2/1/24
20-UNDERTAKER.	**ADDRESS**
Geo. H. Berendson	2503 Edmondson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

D 83287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 v 69 31 D 83287

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Annapolis Rd St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Dorsey

(Residence in Baltimore) No. Annapolis Rd West of Balt St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Mal	Colored	Widower

6-DATE OF BIRTH. Nov (Month) 10 (Day) 1868 (Year)

7-AGE. 55 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Brickyard

9-BIRTHPLACE, (State or Country). Prince George Co

PARENTS.

10-NAME OF FATHER. Peter Dorsey

11-BIRTHPLACE OF FATHER, (State or Country). Prince George Co

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Prince George Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Dorsey

(Address) 530 W Conway St

15 Filed JAN 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry) find that said deceased came to Cause death on the day stated above.

The CAUSE OF DEATH* was as follows:

Exposure to Extreme Cold Froze to death

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) James M Fenlon M. D. (Coroner.)

Jan 28 1924 (Address) Tovey Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	1-31-1924
20-UNDERTAKER. David Easton	ADDRESS 716 [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83288

HEALTH DEPARTMENT—CITY OF BALTIMORE

15002 D 83288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N. Milton ave ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Saunders

(a) RESIDENCE NO. 714 N. Milton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Saunders

6 DATE OF BIRTH (month, day, and year) June 9 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Boston, Va

PARENTS

10 NAME OF FATHER James H. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER " " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs Wm Chadwick (Address) 714 N. Milton Ave

15 JAN 3 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, to Jan. 30. 1924,

that I last saw him alive on Jan 29, 1924,

and that death occurred, on the date stated above, at 3 1. m.

The CAUSE OF DEATH* was as follows:

Chronic Pallgia

9.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza Pneu

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Thayer M. D.

1/31, 1924 (Address) 1134 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Feb 2 1924
20 UNDERTAKER C. A. Wiedefeld Jr	ADDRESS 501 E 22 St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83289

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

10-001 D 83289

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 502 Bruna St ..... St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Tiny Smallwood

(a) Residence No. 502 Bruna St ..... St., ... Ward. Balto Co

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. Blk

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feby 28/1922

7-AGE. 1 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work — ppp

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER. John Henry Smallwood

11-BIRTHPLACE OF FATHER (city or town) (State or Country). St Mary Co

12-MAIDEN NAME OF MOTHER. Gertrude Bird

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Co

14- (Informant) Gertrude Smallwood

(Address) 502 Bruna St

Registered ..... 192.. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/30/24

17. I HEREBY CERTIFY, That I attended deceased from Jany 24 ..... 1924 to Jany 30 ..... 1924, that I last saw him alive on ..... 1924 and that death occurred, on the date stated above, at 7.30 A ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis ppp

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Gustav Hohenemser M. D

, 19 (Address) 1656 N Franklin

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Glenwood Mch — DATE OF BURIAL, 2-1-1924

20-UNDERTAKER. Denis Eastes — ADDRESS 916 Pa ave

IMPORTANT: THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83290

CERTIFICATE OF DEATH.

100-001

D 83290

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 N. Mount St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Irish Queen

(a) Residence No.... 508 N. Mount St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 11-1923

7-AGE. Yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Irish Queen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Daisy Simmons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md

11- (Informant) Daisy Queen

(Address) 508 N. Mount St.

15-

Filed JAN 31 1924 (Signed) ROBERT R. KRAUTER (Registrar)

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan. 30-24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 21- 1924 to Jan. 29- 1924

that I last saw alive on Jan. 29- 1924

and that death occurred, on the date stated above, at 7-40 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos. C. McCorkle M. D

19 (Address) 2410 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, 2-1 1924

20-UNDERTAKER. David Carton

ADDRESS 916 Ga ave

IMPORTANT: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83291

101-001

D 83291

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 933 Wilmer alley ST.) 17 WARD)

2-FULL NAME West James

(a) RESIDENCE. No. 933 Wilmer Alley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer William Price

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Mitchell James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant David Easton
(Address) 916 Pa ave

15 Filed JAN 31 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1—29—1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 —, 1924, to Jan 29th, 1924, that I last saw him alive on Jan 29th, 1924, and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Jas C Casey, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cem	2-1-1924
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83292

CERTIFICATE OF DEATH.

129 D 83292

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 E 33rd ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. Baker

(a) RESIDENCE (No. 2905 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 26 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	41	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): out

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: James M Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary E Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James Baker

(Address): 2905 E. Balto St.

15 JAN 31 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-10-23, 19..., to Jan 28-24, 19...,

that I last saw h[illegible] alive on Jan 27-24

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. R. Brennan, M. D.

(Address) 1-31-24 1,0,2,3,8,4,1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery

DATE OF BURIAL: 2/1 1923

20 UNDERTAKER: John A. Noonan

ADDRESS: 3000 E Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83293

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 247 S. Castle ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Hagan

(a) RESIDENCE NO. 247 S. Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Hagan

6 DATE OF BIRTH (month, day, and year): Uncertain

7 AGE — Years: 86 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: — McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Agnes Hagan 247 Castle St

15 Filed JAN 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Jan. 29, 1924,

that I last saw h[er] alive on Jan. 28, 1924.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

2
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Cassano, M. D.

1.30.24. 19 (Address) Ten Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral Cemetery — DATE OF BURIAL: February 1, 1924

20 UNDERTAKER: John A. Moran — ADDRESS: 80 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 83294

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Town St. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Gilleas.

(a) RESIDENCE NO. 3500 Town St. ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Gilleas

6 DATE OF BIRTH (month, day, and year) April 9- 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James St. Bayliss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Maria V. Pyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Bernard Gilleas

(Address) 3500 Town St.

15 Filed JAN 3 1924, 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923, to Jan 29, 1924

that I last saw h alive on Jan 29, 1924

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Auto Intoxication

Acc Pulm Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirr. Kidney Gyneer 7 Brst

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Sadler, M. D.

Jan. 31, 1924 (Address) 3323 E. Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Francis Cem Abingdon

DATE OF BURIAL Feb 1 1924

20 UNDERTAKER Tilly & Zeiler

ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1/29 83295

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Lewis Thompson

(a) RESIDENCE No. Kent Island ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced, (write the word)~~
Female	white	widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Wm. W. Thompson

6 DATE OF BIRTH (month, day, and year) ~ 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Clendaniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Closure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lottie Bartlett

(Address) Emmanuel Co, Md

15 JAN 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to Jan 31, 1924, that I last saw h[illegible] alive on Jan 31, 1924, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

Unknown

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic Endocarditis Decompensation

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Wilkinson, M. D.

, 19 (Address) 1111 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Love Point, Md

DATE OF BURIAL Jan 31, 1924

20 UNDERTAKER Wm Cook Son & Funeral Dir

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

mclure

D 83296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83296

CERTIFICATE OF DEATH.

99-00

D 83296

1-PLACE OF DEATH

City of BALTIMORE: (No. 1021 Argyle Ave St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James McClure

(a) Residence No. 1021 Argyle Ave St., ... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) March 1-1923

7-AGE.	If LESS than 1 day,
..... yrs. 10 mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... no

(b) General nature of industry, business, or establishment in which employed (or employer) ..... no

(c) Name of employer .....

9-BIRTHPLACE (City or Town) Baltimore City

(State or Country) .....

PARENTS.

10-NAME OF FATHER, John McClure

11-BIRTHPLACE OF FATHER (city or town) .....

(State or Country), Va

12-MAIDEN NAME OF MOTHER, Florence Johnson

13-BIRTHPLACE OF MOTHER (city or town) .....

(State or Country) Md.

14-

(Informant) Florence McClure

(Address) 1021 Argyle Ave

15-

FILED JAN 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-29-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 ....., 1924 to Jan 30 ....., 1924

that I last saw him alive on Jan 29 ....., 1924

and that death occurred, on the date stated above, at 1.20 P. M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

.....

.....

.....

.....(Duration) ..... yrs. ..... mos. 25 ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) John C Stewart, M. D

, 19 (Address) 704 W Lafayette Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn Cem	2-1-, 19 24
20-UNDERTAKER,	ADDRESS 916
Daniel Eastburn	Cathedral

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No Autopsy

Spec.—1-10-21—M&T—1500 Bks.

D 83297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83297

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hezekiah Hillard

(a) RESIDENCE NO. 1214 Jefferson st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Hezekiah Hillard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Coker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 31 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to Jan. 28, 1924, that I last saw him alive on Jan. 28, 1924, and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Sputum

(Signed) Lillie Lally, M. D.

1-28, 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 1, 1923
20 UNDERTAKER	ADDRESS
Joseph D. H. Rogers	4 Jefferson

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 83298

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 E. Oliver ST., 8 WARD)

2-FULL NAME Anna R Clifford

(a) RESIDENCE No. 1610 E Oliver ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word)
Femal	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Thomas Clifford

6 DATE OF BIRTH (month, day, and year) Jan 27 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER John McGuigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Anna McGuigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Edward F. Clifford
(Address) 1610 E Oliver St.

15 Robert P. Harrison, Registrar

JAN 31 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to Jan 29, 1924, that I last saw her alive on January 29, 1924, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Fibrinous Pleurisy

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm R Straight, M. D.

Jan 30, 1924 (Address) 703 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Feb 1924
20 UNDERTAKER	ADDRESS
Geo. J. Rutt	1730 Harford Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACCURATE AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83299

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D 83299

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1808 Wilhelm St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Thomas G. Thorle

(a) Residence No.... 1808 Wilhelm St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ella Thorle

6-DATE OF BIRTH (month, day and year) Sept. 14, 1868

7-AGE. 55 yrs. 9 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... A & P

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... A. A. Co. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Thorle

11-BIRTHPLACE OF FATHER (city or town)..... A. A. Co. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Anderson

13-BIRTHPLACE OF MOTHER (city or town)..... A. A. Co. (State or Country), Md.

14- Ella Thorle (Informant).....

(Address)..... 1808 Wilhelm St.

15- Robert P. Harrison,

Filed..... 192.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1/28/24

17- I HEREBY CERTIFY, That I attended deceased from 1/16 19 24 to 1/29 19 24 that I last saw h— alive on 1/28 19 24 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration)..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension 2

(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical only

(Signed) [illegible] M. D.

1/30, 1924 (Address) 1724 Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cem. DATE OF BURIAL. 2/1/24, 19....

20-UNDERTAKER. George J. Kelly ADDRESS 1735 Hanover

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

FEB 1 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83300

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 6th Street Monell Park Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George William Allick

(a) Residence No. 1108 6th Street Monell Park Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yr. [redacted] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 23, 1923

7-AGE, ...yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Andrew J. Allick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Caroline D. Dantony

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) George William Allick

(Address) 1108 6th Street Monell Park

15- Filed JAN 31 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jany 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 23 1924 to Jany 30 1924

That I last saw h.. alive on Jany 20 1924

and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Premature birth born at 8 mos

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Lack of care or Malnutrition

(Duration) ....yrs. 1 mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Geo. Lentz Pfeiffer M. D

Jan 31 1924 (Address) 230 East Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Vincent | DATE OF BURIAL, Feb 1, 1924

20-UNDERTAKER, Wm Cook | ADDRESS 502 East Monument

should be carefully supplied EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83301

CERTIFICATE OF DEATH.

D 83301

1-PLACE OF DEATH

City of BALTIMORE: (No. 1406 E. Fort ave. St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna McCarthy

(a) Residence No. 1406 E. Fort St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis McCarthy

6-DATE OF BIRTH (month, day and year) June 24 1853.

7-AGE. 69 yrs. 7 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework,

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Patrick Sweeney

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Anna Crowley

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14-Informant Michael McCarthy

(Address) 1406 E Fort Ave

15-Filed JAN 31 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) January 29. 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 23. 19 24 to Jan 29 19 24

that I last saw h.e alive on Jan 29 19 24

and that death occurred, on the date stated above, at 5.P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. F. G. Sloan M. D

1/30. 1924 (Address) 2878 Hartwood Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral — DATE OF BURIAL. Feb. 1 1924

20-UNDERTAKER. Margaret D. Flynn — ADDRESS 1422 Light St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 83302

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hosp ST. 9 WARD)

2-FULL NAME Mrs Oline Jalon

(a) RESIDENCE NO. 2011 Boone ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 53 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. C Jalon

6 DATE OF BIRTH (month, day, and year): Sept 30-1870

7 AGE: Years 53 Months 3 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: Housewife
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (City or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) Balto (State or country) Md

14 Informant (Address) Geo C Jalon 2011 Boone St

15 Filed JAN 31 1924, 19.. Robert F. Harriet. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30 1924

17 I HEREBY CERTIFY, That I attended deceased from 11-14, 1923, to 1-30, 1924.

that I last saw her alive on 1-30, 1924.

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Terminal.

(duration) yrs. 20 wks mos. ds.

CONTRIBUTORY (Secondary) Anemia, Cardiac dilatation

(duration) yrs. mos. 5 Mo.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-16-23

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno. Thompson, M. D.

(Address) Mt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 2 1924
20 UNDERTAKER	ADDRESS
F. D. Hufford	2236 Fred'k

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumonia done for
Illness Pneumococcus.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83303

CERTIFICATE OF DEATH.

74-901 ✓ D 83303

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp 70 St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Stroheker

(a) Residence No. 2746 Wilkens Ave St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mar 15th 1866

6-DATE OF BIRTH (month, day and year) Jan 31

7-AGE, 57 yrs. 8 mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Hair Spinner

(b) General nature of industry, business, or establishment in which employed (or employer). Welkens Co

(c) Name of employer. .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER. John McStrohecker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Schafer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

11- (Informant) Anna M. Hamilton

(Address) 47 Furman Ave

15- Filed ..... 192 ..... Registrar.

Robert P. Harrison,

JAN 31 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 31st

17- I HEREBY CERTIFY, That I attended deceased from Jan 28 1924 to Jan 31 1924

that I last saw him alive on Jan 30 1924,

and that death occurred, on the date stated above, at 1.55 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) S. Goldman M. D

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Auburn Cemetery

DATE OF BURIAL. Feb 4th 1924

20-UNDERTAKER. J B Weisfeld

ADDRESS 2236 Fleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 83304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83304

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3605 E Pratt St. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Wolf

(a) RESIDENCE. No. 3605 E. Pratt St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Wolf Sr

6 DATE OF BIRTH (month, day, and year) Sept 24-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bayta, Mus

PARENTS

10 NAME OF FATHER Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant H. J. Wolf (Address) 3605 E. Pratt St

15 Filed Robert F. Harrison, Registrar

N3 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 1924, to 1-29, 1924, that I last saw h alive on 1-29, 1924, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Asc Pulm Oedema
Acute Intoxication

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemoklysis (apoplexy)
Chr Int Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Weller M. D.

1/31, 1924 (Address) 3322 Dallas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Memorial Cemetery	Feb 1st 1924
20 UNDERTAKER	ADDRESS
F. B. Kuppert	2216 Fleet Ave

INFORMATION—THIS IS A PERMANENT RECORD; EVERY item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83305

CERTIFICATE OF DEATH.

46 D 83305

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1226 7th, St, Morrell Park 25 WARD)

2-FULL NAME. Magdalena Koziel,

(a) RESIDENCE. No. 1226 7th, St, Morrell Park WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or WIFE of Paul Koziel

6 DATE OF BIRTH (month, day, and year) July 22-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Hermand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Paul Koziel
(Address) 1226 7th St. Morrell Park

15 Filed JAN 31 1924, 19 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13-, 1923, to Jan 31-, 1924, that I last saw her alive on Jan 30, 1924, and that death occurred, on the date stated above, at 5.30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteres

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Ethelbert Hennessy, M. D.
1/31. 1924 (Address) 2000 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feby. 2 1924
20 UNDERTAKER	ADDRESS
J. Wm. Offutt, Sr.	115 S. Harrison

Sane

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83306

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1846 W Pratt St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony E. McManus

(Residence in Baltimore: No. 1846 W Pratt St (yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1857 (Year)

7-AGE.	If LESS than 1 day,
37 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Highway Engineer

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Terence McManus

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Catherine Daly

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward S McManus

(Address) 1846 W Pratt St

15- Filed JAN 31 1924 192 Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 30 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Hanlon M. D. (Coroner)

Jan 31 192 4 (Address) 707 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	Feb. 2 1924

20-UNDERTAKER,	ADDRESS
J & B Cook	1003 W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83307.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83307.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Eutaw Place ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Whitehurst

(a) RESIDENCE. NO. 1501 Eutaw Place ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer of 045

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor Medicines

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER J. Harrison Whitehurst

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie L. McElvain

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Dr. H. H. Whitehurst
(Address) 1501 Eutaw Place

15 Filed JAN 31 1924, 19 Robert P. Harrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1924, to Jan 30, 1924, that I last saw him alive on Jan 30, 1924, and that death occurred, on the date stated above, at 4 A- m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John R. Abercrombie M.D.

1/30, 1924 Address 3524 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LoudonPark Cemetery	Feb. 1 1924

20 UNDERTAKER Jos B Cook

ADDRESS 1003 W Balto

—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lobular

Spec.—1-10-21—M&T—1500 Bks.

D 83308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83308

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Edmondson Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander J. Peed

(a) RESIDENCE No. 1108 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Didier Peed

6 DATE OF BIRTH (month, day, and year) Jan 13 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or estsblishment in which employed (or employer) 066

(c) Name of employer Merritt Elliott Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine ?.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mr. Edgar A. Peed

(Address) 1108 Edmondson Ave.

15 Filed JAN 31 1924, 19

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Jan 30, 1924, that I last saw h[illegible] alive on Jan 29, 1924, and that death occurred, on the date stated above, at 4.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis & myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) J. W. Chesney, M. D.

1/31, 1924 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 1 1924
20 UNDERTAKER Wm Tuckerman Sons	ADDRESS Norfolk Va

N.B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83309

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1294

D 83309

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE: (No. 211 E. 24th St. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Louisa Mason

(Residence in Baltimore: No. 211 E. 24th St. St.; 75 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female — 4-COLOR OR RACE: White — 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: June (Month) 15 (Day), 1839 (Year)

7-AGE: 84 yrs. 7 mos. 13 ds. — If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ..... Wd

9-BIRTHPLACE (State or country): New York City

PARENTS

10-NAME OF FATHER: Charles Snider

11-BIRTHPLACE OF FATHER (State or country): Copenhagen, Denmark

12-MAIDEN NAME OF MOTHER: Phoebe Somerville

13-BIRTHPLACE OF MOTHER (State or country): Belfast, Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. P. Turner

(Address) 211 E. 24th St

15- Robert P. Harrison,

JAN 31 1924, 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January (Month) 30 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1923, to Jan. 30 1924, that I saw her alive on Jan. 30 1924, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (SECONDARY) Coma

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) E. T. Bruehl M. D.

Jan. 31 1924 (Address) 204 St. Paul St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Feb. 1 1924

20-UNDERTAKER: W. J. Tickner Sons — ADDRESS: North Penna Ave

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83310

CERTIFICATE OF DEATH.

31

5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Baily

(a) RESIDENCE No. 26 N. High st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ellick Baily

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 3 1924, 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to Jan. 28, 1924.

that I last saw him alive on Jan. 28, 1924,

and that death occurred, on the date stated above, at 6.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally, M. D.

1-28, 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt. Patrick

DATE OF BURIAL 2/1 1924

20 UNDERTAKER J. J. Fahey, Home

ADDRESS 1318 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 001

D 83311

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 864 W Fayette St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Adams

(Residence in Baltimore: No. 864 W Fayette St St., yrs., mos. ds.)

Unknown

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Don't Know

6-DATE OF BIRTH. Don't Know (Month) (Day) 1..... (Year)

7-AGE. About 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Don't Know
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Don't Know

PARENTS.

10-NAME OF FATHER. "

11-BIRTHPLACE OF FATHER. (State or Country). "

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dont

(Address)

15- Robert F. Harrison,

JAN 31 1924 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 28 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) ..... M. D. (Coroner.)

192.... (Address)

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holdrow & Co	2/1 1924
20-UNDERTAKER,	ADDRESS,
J. Valley Howe	318 Light St

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83312

CERTIFICATE OF DEATH.

101-981 ✓ D 83312

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1041 N. Mc Central St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgeanna Seeton

(a) Residence No. 1041 N. Central St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel C.

6-DATE OF BIRTH (month, day and year) April 17-1853

7-AGE, 70 yrs. 9 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12-MAIDEN NAME OF MOTHER, Margaret Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) William Brown

(Address) 2641 Eastern

15- Filed JAN 31 1924, Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 30/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 24, to Jan 30 24

that I last saw h[illegible] alive on Jan 30 24

and that death occurred, on the date stated above, at 9:35 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1/2 ds.

18-Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

1/30, 1924 (Signed) Karl J. Douglas M. D.

(Address) 702 E Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore

DATE OF BURIAL, Feb 2 —, 1924

20-UNDERTAKER, William Cook

ADDRESS 502 E North Ave

JAN 31 1924

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83313

CERTIFICATE OF DEATH.

76

1-PLACE OF DEATH Graceland Park

Registered No.....

City of BALTIMORE: (No. Bessemer Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Pauline Funk

(a) Residence No.... Bessemer Ave St.,.....Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, ~~widowed~~, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W Funk

6-DATE OF BIRTH (month, day and year) Jan 31-1843

7-AGE, 81 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)..... Mrs Funk

(Address) Bessemer Ave Govt 26

15- Filed..... Robert P. Harrison, Registrar.

JAN 3 1924

Federal Death Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-31-24

17- I HEREBY CERTIFY, That I attended deceased from August, 1923 to Jan 31, 1924, that I last saw her alive on Jan 14, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

.....(Duration).....yrs. 1 mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)..... Chas Reuter, M. D.

Jan 31, 1924 (Address) 1 Windsor Rd. Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, Feb 2, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 507 E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Blks.

D 83314 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 83314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 12 57

City of BALTIMORE: (No. Municipal Hospital. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Russell

(a) Residence No. 402 E. 22nd St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1850 1850

7-AGE. 74 yrs. 10 mos. 0 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.
10-NAME OF FATHER, Eugene J. Russell
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mississippi.
12-MAIDEN NAME OF MOTHER, Susanna Medley.
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Municipal Hospital Records
(Address)

15- JAN 1924 Robert P. Harrison, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 26 19 24 to January 29 19 24
that I last saw her alive on January 29 19 24
and that death occurred, on the date stated above, at 6:50 P.M.
The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings
(Signed) Wm J Faulton, M. D
1-30- 19 24 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Feb 2 19 24

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Pratt

N3

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83315 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH. 8 101-601 D 83315

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas T. Powling

(a) Residence No. 1722 Lafayette Ave. St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 25, 1875

7-AGE. 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer). ost

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER. Harrison Bowling

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Voughn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant) Municipal Hospital Record

(Address).....

15-FEB 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 14 19 24 to January 30 19 24

that I last saw him alive on January 29 19 24

and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S Dixon, M. D

1-30-24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. Feb 1, 1924

20-UNDERTAKER. Robt J Turner & Sons ADDRESS 1742 N Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83316

REGISTERED NO.

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Pl. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Sandler

(a) RESIDENCE NO. 810 Asquith St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Mr. Jacob Sandler

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sini - Russian Poland.

PARENTS

10 NAME OF FATHER Harry Hoffman

11 BIRTHPLACE OF FATHER (city or town) Sini (State or country) Russian Poland

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) Sini (State or country) Russian Poland.

14 Informant (Address) J. Levin 1499 E. Baltimore St.

15 FEB 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to Feb 1, 1924.

that I last saw her alive on Jan 31, 1924,

and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma - stomach

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan 29, 24.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Grant Edward., M. D.

2/1, 1924 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	Feb. 1 1924

20 UNDERTAKER Jacob Levin ADDRESS 1499 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83317 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4617 old Pimlico Rd St., 15 Ward) 31

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Goldman

(a) Residence No. 4617 old Pimlico Rd St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Goldman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Ho

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Solomon Goldman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 Eastern Ave

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

FEB 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 1/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 19 23 to Jan 31st 19 24

that I last saw him alive on Jan 31st 19 24

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows: Tuberculosis of Lungs

(Duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. O'Leary M. D.

, 19 (Address) 1920 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Bate. Hebrew Cem. DATE OF BURIAL, Feb 1 19 24

20-UNDERTAKER, Jack Lewis ADDRESS 1439 E. Balto.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 83318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83318

CERTIFICATE OF DEATH.

90

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3639 Roland Ave 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Webb

(a) RESIDENCE NO. 3639 Roland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie V Webb

6 DATE OF BIRTH (month, day, and year) Jan 5 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	27		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Ste

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Samuel Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Lottie A Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Janie Fisher

(Address) 3639 Roland Ave

FEB 1 - 1924 Filed ROBERT W. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 31, 1924, that I last saw h.. alive on Jan 31, 1924, and that death occurred, on the date stated above, at 6:40 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Regurgitation

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? (over)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) C. F. Culbreth, M. D.

1-26-24 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Feb 2 1924

20 UNDERTAKER GRENOWETH & SON, — ADDRESS 3617 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Asthma

Spec.—1-10-21—M&T—1500 Bks.

D 83319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83319

X118-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Frank A Otto

(a) RESIDENCE NO. Baldwin, Md. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. -- mos. 4 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Lindeman

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Mail Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Frank Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant (Address) Mrs. Margaret L. Otto Baldwin, Balto. Co., Md.

FEB 1 - 1924

Filed ROBERT H. KRAUTER, Burial Permit Clerk Registrar

Rauw.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 31 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/23/24, 1924, to 1/31/24, 19..., that I last saw him alive on 1/31/24, 19..., and that death occurred, on the date stated above, at 6:15 P.m.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 1/24/24

Was there an autopsy? None

What test confirmed diagnosis? Bacteriological

(Signed) L. M. Pelouze, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	2/4 1924
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of state TION is very important. See instructions on back of certificate. CERTIFICATE.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hernia

Spec.—8-24-14—M. & T.—2000 Bks.

83320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83320

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH 1140 Belair Rd

CITY OF BALTIMORE (No. 1140 Belair Rd ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Capprise

(Residence in Baltimore: No. 1140 Belair Rd St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 9, 1856 (Month) (Day) (Year)

7-AGE, 67 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer Oth
(b) General nature of industry, business, or establishment in which employed (or employer) "

9-BIRTHPLACE, (State or Country) Louisiana U.S.

PARENTS.

10-NAME OF FATHER, Joseph C Capprise

11-BIRTHPLACE OF FATHER (State or Country) Louisiana

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma E. French

(Address) 1140 Belair Rd

15- FEB 1 - 1924 ROBERT R. KRAUTER, 191.. Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 1924, to Jany 31 1924, that I saw h alive on Jany 2 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cancer of bowel

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C L Cotrell M. D.

Jan 31 1924 (Address) Gardenville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Feby 6, 1924

20-UNDERTAKER John Ullrich — ADDRESS 2008 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83321 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83321

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 2611 E Fayette St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Froehlich

(a) Residence No. 2611 E Fayette St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Balthasar Froehlich

6-DATE OF BIRTH (month, day and year) Sept 28-1834

7-AGE 89 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS:

10-NAME OF FATHER, Gort Kron

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12-MAIDEN NAME OF MOTHER, Gort Kron

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14- (Informant) Mrs F. Enders

(Address) 2611 E. Fayette

15- ROBERT R. KRAUTER, Registrar.

FEB 1 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 31-1924

17- I HEREBY CERTIFY, That I attended deceased from January 26th 1924 to January 31 1924 that I last saw h... alive on January 30th 1924 and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronco-Pneumonia

(Duration) 4 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Oedema

(Duration) 4 yrs. 4 mos. 4 ds.

18-Where was disease contracted if not at place of death? 4

Did an operation precede death? No Date of 4

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) William G. Morton M. D.

, 19 (Address) 2919 Huntingdon Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	Feby 2 1924
20-UNDERTAKER, John Ellis	ADDRESS 2008 Eutaw

H. Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE ... TH ... See ... In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83322

129

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1920 Orleans St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Hahn

(a) Residence No. 1920 Orleans St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wilcoxon

6-DATE OF BIRTH (month, day and year) Oct 1870

7-AGE. 53 yrs. 3 mos. ds. If LESS than 1 day, hrs. or, min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Frederick Md

PARENTS.

10-NAME OF FATHER, William Hahn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Katherine Haller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) George Davis

(Address) 1920 Orleans

ROBERT R. KRAUTER, Registrar.
ROBERT R. KRAUTER, Burial Permit Clerk.
FEB 1 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 31-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2 1923 to Jan 31 1924

that I last saw her alive on Jan 31 1924

and that death occurred, on the date stated above, at 1.15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B P Herzog M D

2/1 1924 (Address) 1305 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Frederick Md — DATE OF BURIAL. Feby 3 1924

20-UNDERTAKER. John Lellers — ADDRESS 2008 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Blks.

D 83323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83323

181-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S. Sharp St. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Bechney.

(a) RESIDENCE NO. 516 S. Sharp St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -- ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boiler maker
(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Department. Southern
(Address)

FEB 1 - 1924 ROBERT R. KNOTT, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphyxia.
Accidental Death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto K. Reinhardt, M. D.
(Coroner.)

Feb. 1st. 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a. a. DATE OF BURIAL: Feb 1 1924

20 UNDERTAKER: John Grebbinskas ADDRESS: 425 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83324

CERTIFICATE OF DEATH.

90 D 83324

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2001 N. Fulton Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Webb

(a) Residence No. 2001 N. Fulton Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July - 1863

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER William Hale

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Polly Kendell

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country) Maryland

14- (Informant) Julian Webb

(Address) 2801 Parkwood Ave

15- FEB 1 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 1 - 31 - 24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1923 to 1-31, 1924, that I last saw h[illegible] alive on 1-30, 1924, and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (121)

(Duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Bruger M. D.

2/1, 1924 (Address) 1928 W. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Londen Park — DATE OF BURIAL, Feb. 2, 1924

20-UNDERTAKER Josiah Leyfer — ADDRESS 1600 W North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83325

CERTIFICATE OF DEATH.

90

D 83325

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 106 W. Hamilton Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Frederick Meyer.

(a) Residence No. 106 W. Hamilton Ave St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Caroline Meyer

6-DATE OF BIRTH (month, day and year) June 17, 1854

7-AGE. 69 yrs. 7 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Slate roofer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 11 years

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs. Caroline Meyer

(Address) 106 W. Hamilton Ave.

15.

Filed FEB 1 - 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 29, 1924

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1924, to Jan 29, 1924

that I last saw h[illegible] alive on Jan 29, 1924

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency with Auricular Fibrillation

Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Mencz M. D

, 19 (Address) 1 W. Mt. Royal Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Feb. 1, 1924

20-UNDERTAKER. H. Sander's Sons

ADDRESS 1710 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83326

CERTIFICATE OF DEATH.

31 ✓ D 83326

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2419 Stockton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Branch

(a) RESIDENCE. No. 2419 Stockton ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-4-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Howard Woolford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Adams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Susie Branch
(Address) 2419 Stockton St.

15 Filed FEB 1 - 1924 19 Registrar

Burial Permit Clerk.

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30- 1924

17

I HEREBY CERTIFY, That I attended deceased from June 10 1923, to 1-30 1924,

that I last saw h.. alive on 1-30- 1924,

and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no. Date of ✓

Was there an autopsy? no.

What test confirmed diagnosis? ✓

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wyoming Star Cemetery	Feb 2. 1924
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1725 Eastland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83327

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-801 ✓ D 83327

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Moyer St. 6 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Marguerite Davis

(Residence in Baltimore: No. 5 weeks and 4 days 2117 Moyer St.; 1yr. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Infant

6-DATE OF BIRTH: December 23 1923 (Month) (Day) (Year)

7-AGE: 1 yrs. 1 mos. 9 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE (State or country): 2117 Moyer St Balto Md

PARENTS

10-NAME OF FATHER: Lawrence Davis

11-BIRTHPLACE OF FATHER (State or country): Balto Md USA

12-MAIDEN NAME OF MOTHER: Carrie Keller

13-BIRTHPLACE OF MOTHER (State or country): Balto Md USA

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lawrence R. Davis

(Address) 2117 Moyer St

15-

FEB 1 - 1924 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 31st 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to Jan 30 1924, that I saw him alive on Jan 30 1924, and that death occurred, on the date stated above, at 7 30/4 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel Silverstein M. D.

Jan 31st 1924 [Address] 22 S. Bond

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: [illegible]

DATE OF BURIAL: February 1, 1924

20-UNDERTAKER: Wendell Disselson

ADDRESS: 37 Adam St

D 83328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

34 D 83328

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Herman Hospital ST. 28 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Diehl

(Residence in Baltimore: No. Herman Hospital St.; 6 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: March 23, 1906 (Month) (Day) (Year)

7-AGE: 17 yrs. 10 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Pennsylvania

PARENTS

10-NAME OF FATHER: Jacob Diehl

11-BIRTHPLACE OF FATHER (State or country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Mazie Wright

13-BIRTHPLACE OF MOTHER (State or country): Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Record

(Address) .....

15 Filed FEB 1 - 1924 ROBERT R. KRAUTER, REGISTRAR Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 31, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1918, to Jan 31 1924 that I saw her alive on January 31, 1924. and that death occurred, on the date stated above, at 8 20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Streptococcus infection throat - TB Spine Lumbar

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Wilder H Darnall M. D.

Jan 31, 1924 (Address) 1102 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. 7 mos. 29 ds. In the State 5 yrs. 7 mos. 29 ds.

Where was disease contracted, if not at place of death? Pennsylvania

Former or usual residence Fawn Grove Pa.

19-PLACE OF BURIAL OR REMOVAL: York Pa — DATE OF BURIAL: 2-1-1924

20-UNDERTAKER: Earl B Hake — ADDRESS: 115 E West

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D 83329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83329

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital, ... St., ... 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford Smith

(a) RESIDENCE NO. 216 N. Mercer ST., ... WARD West End

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Smith

6 DATE OF BIRTH (month, day, and year) Aug - 1900

7 AGE: Years 24 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash DC

14 Informant P A Lowe Wash DC

(Address) 1400 R St NW

FEB 1 - 1924 Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to Jan 31, 1924, that I last saw him alive on Jan 31, 1924, and that death occurred, on the date stated above, at 5 00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pernicious anaemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? ..... Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Blood

(Signed) John A. Schwenck, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C. — DATE OF BURIAL 2/1 1924

20 UNDERTAKER Samuel F Kennedy — ADDRESS 578 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Theodore R. Rumney

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83330

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74 D 83330

Registered No. C.....

City of BALTIMORE: (No. 607 Scott St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore R. Rumney

(Residence in Baltimore: No. 607 Scott St St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced (Write the word.)
Male	W.	Widower

6-DATE OF BIRTH. May 25 1864.
(Month) (Day) (Year)

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Iron Worker
(b) General nature of industry, business, or establishment which employed (or employer). Co

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Theo Rumney

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Joseph Welch

(Address) 607 Scott St

FEB 1 - 1924 Filed 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 30 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, or copy of inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) a few hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) W. R. Forsaith M. D.
(Coroner.)

2-1-, 192 (Address) 1101 Dawson St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Bait Cem	2/3/24

20-UNDERTAKER.	ADDRESS
Jno C Denny	116 Fifth St

D 83331

Spec. 1-09-31 M&C—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 83331

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 William St. ST. 24 WARD)

2-FULL NAME Mary C.Mace

(a) RESIDENCE NO. 806 William St. ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William O.Mace

6 DATE OF BIRTH (month, day, and year) October 9 '58

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co.Md.

PARENTS

10 NAME OF FATHER Samuel Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Garner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs.Andrew Schultz

(Address) 806 William St.

FEB 1 1924 Filed ..... 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan.30 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Jan 30, 1924.

that I last saw h.. alive on Jan 30, 1924,

and that death occurred, on the date stated above, at 5.10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

1-31. 1924 (Address) 120 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Feb 1 1924

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

N. B.—Every Physician, Midwife or Undertaker is required by law to report every death to the Health Department within 24 hours. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM

Spec.—1-10-21—M&T—1500 Bks.

D 83332

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 83332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4510 Lanvale ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Schmidt

(a) RESIDENCE NO. 4510 Lanvale ave ST., Lanvale WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schmidt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Gro.

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer —

9 BIRTHPLACE (city or town) Green Spring

(State or country) Baltimore County

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) Green Spring

(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER B. Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore County

14 Informant Mrs. Anna Schmidt

(Address) 4510 Lanvale ave

15 Filed FEB 1 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30. 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1923 to Jan 30, 1924,

that I last saw h~~e~~live on Jan 30, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxemia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Sarcoma

Colon (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? over

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Young, M. D.

(Address) 4716 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Evang. L. Cemetery	Feb 2 1924

20 UNDERTAKER George F. Rueth ADDRESS 1735 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

6821

ETY

S. A. E.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83333

CERTIFICATE OF DEATH.

161-001 D 83333

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. 5 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cohen

(a) RESIDENCE NO. 611 N. Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31, 1924

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Israel Cohen

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Julia Michelson

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant

(Address)

Filed FEB 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924. to Jan 31, 1924.

that I last saw h alive on Jan 31, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Baby - 6 mo.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidor J. Fry, M. D.

Jan 31 '24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL: FEB 1 1924 19

20 UNDERTAKER: Commissioner Health. per Wm. E. WOODALL.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

36

COPY OF BACK

Spec.—1-10-21—M&T—1500 Bks.

D 83334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83334

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Mondt St. 15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia A. Graham

(a) RESIDENCE No. Clifton & Dukeland Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Graham, Jr.

6 DATE OF BIRTH (month, day, and year): June 15 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John McGowan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Walter Graham Jr 1723 Longwood St

15 Filed FEB 1 1924, 19 Robert P. Warfield, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/31 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1924 to Jan. 31, 1924

that I last saw h alive on Jan. 30, 1924

and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Burn of body thigh & genitals 1st & 2nd degree

Ink (duration) yr mos ds.

CONTRIBUTORY (Secondary) Dementia Praecox 5 days (duration) yr mos. ds.

18 Where was disease contracted if not at place of death? Clift. & Dukeland Ave

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) A. A. Turnbull, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb 2nd 1924
20 UNDERTAKER	ADDRESS
Josiah Leyden	1600 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

J. J. Hennessy

clothing caught (Coroner N. W. 10th
fire from stove while leaving Village

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms). *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: ***Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.*** The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The physician in this case gave certificate without thinking of the case being accidental

J. J. H.

Spec.—1-10-21—M&T—1500 Blks.

D 83335

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 83335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Plymouth ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Harden

(a) RESIDENCE NO. 2012 Plymouth Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 F 1842

7 AGE: Years 81 Months 6 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Horden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ariel Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Md

14 Informant: Mrs Flora Doll

(Address) 2012 Plymouth Ave

15 Filed 19 Robert F. Harrison, Registrar

B 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31st 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7th, 1924, to Jan 31st, 1924

that I last saw h alive on Jan 30th, 1924

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Tabes Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility Hypostasis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hypostasis

(Signed) T. J. Julian, M. D.

Jan 31, 1924 (Address) 1117 Mercer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL: Mayo Chapel Bells Mill DATE OF BURIAL: Feb 2 1924

20 UNDERTAKER: A J Marshall ADDRESS: 3539 Fall Rd

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83336

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 N. Calvert St., 17 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas John Cheer

(a) RESIDENCE No. 3023 N. Calvert St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, or Divorced, (write the word)
Male	White	Widower

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) April 18 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Thomas J. Cheer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Jane B. Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Mr Cheer
(Address) 3023 N Calvert St

15 Filed FEB 1 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Feb 1, 1924, that I last saw her alive on Jan. 30, 1924, and that death occurred, on the date stated above, at 4:00 a. m.

The CAUSE OF DEATH* was as follows:

Generalized arterio Sclerosis
Chronic Myocardiac Insufficiency
(Auricular fibrillation)
Stroke
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G Carroll Lockard M. D.
Feb 1, 1924 (Address) 42 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Creek Cem	Feb 2 1924
20 UNDERTAKER H. Washington & Co	ADDRESS Funeral Directors
H. H. Jenkins & Co	

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 83337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 83337

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St. Ag Hospital ST. 70 WARD)

2-FULL NAME Ida Nicholson

(a) RESIDENCE No 641 Fredrick Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Yrs. 70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Arthur Nicholson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret Stember

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Wm H Stember
(Address) 303 St Paul St

15 Filed FEB 1 - 1924, 192 Albert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 — 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto- accident
Multiple Fractures
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock
(duration) 1 — yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Stades M. D.
Feb 1, 1924 (Address) 143 N Bway
(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 4 1924
20 UNDERTAKER George J Smith	ADDRESS Hollins

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83338

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09 D 83338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1426 E Federal St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Roberts

(a) Residence No. 1426 E Federal St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 20 1916

7-AGE, 7 yrs. 7 mos. 5 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George H Roberts Jr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Rose M Dukar

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Harford Co Maryland

14- (Informant) George H Roberts

(Address) 1426 E Federal st

15- Filed....., 192.....

Robert P. Harrison, Registrar.

~~Burial Permit Clerk~~

FEB 1 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to Jan 30, 1924, that I last saw him alive on Jan 30, 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia 7 Myocarditis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. D. Carman, M. D.

1-31-, 1924 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	Feb 2, 1924
20-UNDERTAKER, George J Smith	ADDRESS 1533 Hollins St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83339

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1740 W Lanvick (St.) 15 (Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Harris

(a) RESIDENCE. NO. 1740 W Lanvick Avenue ST. ..... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wm. S. Harris

6 DATE OF BIRTH (month, day, and year) April 2nd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Adams Co. Pa

PARENTS

10 NAME OF FATHER Wm Aldridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ann Ruben

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ophelia Harris

(Address) 122 Linwood Ave

15 Filed FEB 1 1924, 19.. Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from January 2nd 1924, to January 3rd 1924, that I last saw he alive on January 3rd 1924, and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

..... (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Test

(Signed) Wm Stuart M. D.

1/5, 1924 (Address) 1701 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W Oliver — DATE OF BURIAL Feb 2 1924

20 UNDERTAKER W Bailey & Sons — ADDRESS 1827 W North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83340

CERTIFICATE OF DEATH

161-001 D 83340

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 Mosher ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Brady Willig

(a) RESIDENCE No. 219 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 26 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER George L Willig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Lillie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant George L Willig

(Address) 219 Mosher St

15 Robert C. Harrison, Registrar

B 1 -1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1924, to Jan 31, 1924,

that I last saw h— alive on Jan 31, 1924,

and that death occurred, on the date stated above, at 5:45 P.m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Premature)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Ephraim M. D.

, 19 (Address) 1904 E Baltst

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Lawn [illegible] Cemetery — DATE OF BURIAL 2 2 1924

20 UNDERTAKER Wendell Dippelsman — ADDRESS 37 Sw

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-15-23—M&T—100 Bks.

D 83341

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 83341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 572 So. Robinson ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Grace Eva Palmiere

(a) RESIDENCE No. 572 So. Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1st 23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	2	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Nicholas Palmiere

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosie Delcie

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Nicholas Palmiere
(Address) 572 So. Robinson St

15 Filed FEB 1 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

(Signed) Thos B Norton, M. D.
(Coroner.)

Feb 1st, 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 2 1924
20 UNDERTAKER	ADDRESS
Wendell Dysel & Son	318 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83342

CERTIFICATE OF DEATH.

101-001 D 83342

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Port Street ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Elizabeth Knot

(a) RESIDENCE. No. 1506 Port Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December 19, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland, Baltimore

PARENTS

10 NAME OF FATHER Richard C. Knot

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co. (State or country)

12 MAIDEN NAME OF MOTHER Charlotte R. Hiss

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. (State or country)

14 Informant Mrs. Charlotte R. Knot
(Address) 1506 Port St.

15 Filed FEB 1 - 1924 [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1924, to Feb 1st, 1924

that I last saw h[illegible] alive on Feb 1st, 1924

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Course

(Signed) Geo Mumford Gibbs M. D.

2/1/24 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Pa

DATE OF BURIAL February 5, 1924

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 125 E. North Avenue

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

28 ✓

Raspeburg R.F.D. Philadelphia Road

1-PLACE OF DEATH

Registered No. D 83343

City of BALTIMORE: (No. 260 Bowleys Lane or R.F.D. ... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Ellizson

(a) Residence No. 260 Bowleys Lane near Philadelphia Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the w...

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 28th 1909

7-AGE. 14 yrs. 2 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Co. (State or Country) Maryland

PARENTS.

10-NAME OF FATHER Henry Ellizson

11-BIRTHPLACE OF FATHER (city or town) Balto. Cy. (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Anna M. Bauer

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country) Maryland

14- (Informant) Mrs Anna M. Ellizson

(Address) 260 Bowleys Lane Baltimore Co.

15- Robert L. Harrison

Filed FEB 1 - 1924 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 30 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 29 1924 to Jan 30 1924

that I last saw h... alive on Jan 30 1924

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy (Grand mal)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema during Convulsions

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Sevor M. D.

1/30, 192 (Address) 431 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,	
Holy Redeemer Cemetery	Feb 2	1924
20-UNDERTAKER,	ADDRESS	
Fred K. Lassahn & Sons	Fullerton	

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 83344 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. #7 W. West St., 23 Ward)

Registered No. 1853

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dailey

(a) Residence No. #7 W. West St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 25 1866

7-AGE. 58 yrs. — mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Accidental

(b) General nature of industry, business, or establishment in which employed (or employer). No Inquest held by Coroner

(c) Name of employer. No Return

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Patrick Dailey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Kavanagh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- Informant) John Miller

(Address) #7 W. West St

15- [illegible] 192

Registrar.

FEB 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 30/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 28 19 24 to Jan 30 19 24

that I last saw h alive on Jan 30 19 24

and that death occurred, on the date stated above, at 8:34 m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture femur,

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos A. Schmuck M. D.

19 (Address) 119 E. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St Vincents	2/2/24
20-UNDERTAKER.	ADDRESS
F. A. Francesden	703 Hanover St

All blanks must be carefully supplied. ABC should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83345

CERTIFICATE OF DEATH.

129D 83345

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 W. Yorks. ST., 27 WARD)

2-FULL NAME Lucy Warren

(a) RESIDENCE NO. 7 W. Yorks. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Otis Warren

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West river
(State or country) maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Otis Warren
(Address) 7 W. Yorks St

15 Filed ..... 1924 Robert F. Harrison, Registrar

Burial Permit Clerk!

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 30, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan, 30, 1924, that I last saw h. W alive on Jan, 30, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral + aortic
Endocarditis

(duration) yrs. unknown mos. ds.

CONTRIBUTORY (Secondary) Chr. Diffuse nephritis (duration) yrs. unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? unknown

(Signed) Wm Francis, M. D.

1/31, 1924 (Address) 1111 Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct — DATE OF BURIAL Feb 2 1924

20 UNDERTAKER J. Tee Brown & Son — ADDRESS 1018 W. Mulb

82 - 1924

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. (Allen P. Gillespie ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83346 ✗ 90 D 83346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 E Fairfield ST., 25 WARD)

2-FULL NAME Allen P. Gillespie

(a) RESIDENCE NO. 710 E Fairfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND (or) WIFE Sarah Gillespie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U S

PARENTS

10 NAME OF FATHER Sherman Gillespie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown N C

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U S

14 Informant John A. Gillespie (Address)

15 Filed FEB 1 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 - 1923, to Jan 31 1924, that I last saw h[illegible] alive on Jan 30 - 1924 and that death occurred, on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows: Myocarditis Chronic Nitral Stenosis -

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Coleman M. D.

1924, (Address) 2039 N Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Feb 3 1924
20 UNDERTAKER	**ADDRESS**
L. L. Brown & Son	1011 Monroe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83347 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83347

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2523 E. Biddle ST., 8 WARD)

2-FULL NAME Margaret A. Carmine

(a) RESIDENCE NO. 2523 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of the late William A. Carmine

6 DATE OF BIRTH (month, day, and year) March 17 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Arthur White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Janet Cherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Elsie M. White

(Address) 2523 E Biddle St

15 1924 Robert F. Harrison, .19 Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 .1923, to February 1 .1924 that I last saw her alive on February 1 .1924, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia -

arterial hypertension -

hemiplegia - Dec. 17-1923. (2nd attack Jan 29-1924)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis H. Krumrein, M. D.

.19 (Address) 722 North Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Feb. 4 1924

20 UNDERTAKER Henry Horch Son ADDRESS 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1006 N. Stricker ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Ross

(a) RESIDENCE No. 1006 N. Stricker ST., WARD New Glasgow Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colred	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leslie Ross

6 DATE OF BIRTH (month, day, and year) about 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Amherst Co. Va.
(State or country)

PARENTS

10 NAME OF FATHER Robert Carter

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lizzie Hundley

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Hatty Thompson
(Address) 49 Fenton Place Wash. D.C.

15 Filed FEB 2 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. C. B. Hennessy, (Coroner.) M. D.

Feb. 1, 1924 (Address) 2802 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Glasgow Va — DATE OF BURIAL: Feb 2 1924

20 UNDERTAKER: Wm H Chase Hon — ADDRESS: 1404 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83349

146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Fiorino

(a) RESIDENCE NO. 20 E. York ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Fiorino

6 DATE OF BIRTH (month, day, and year) May 31 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Pasquale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Sam Fiorino

(Address) 20 E York St

15 FEB 2 -1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 1 - 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-25-, 1924, to 2-1-, 1924,

that I last saw her alive on 2-1-, 1924

and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Abortion

(8 mos.)

(duration) yrs. mos. 6hrs ds.

CONTRIBUTORY (Secondary) General Peritonitis

Septicaemia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 1-7-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D. Cox, M. D.

2/1, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery aa Co

DATE OF BURIAL Feb 4 1924

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St

WHITE PAPER, WITH ENGRAVED RINGS. EVERY question and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

According to history case was a spontaneous abortion of 8 weeks pregnancy, which ceased at present time.

Curettage 11/27/- removed only a few clots.

O.K. J. Frederick Hempel
Asst. Coro.

Spec.—1-10-21—M&T—1500 Blks.

D 83350

HEALTH DEPARTMENT—CITY OF BALTIMORE

83350

CERTIFICATE OF DEATH.

101-a

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 N. Washington ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethelyn M. Plunder

(a) RESIDENCE NO. 1721 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Plunder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Laura Morton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant James Plunder (Address) 1721 N. Washington St.

15 Filed FEB 2 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31st 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-26, 1924, to 1-31, 1924, that I last saw her alive on 1-31, 1924, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Manifestation

(Signed) Daniel Miller, M. D.

19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	2/2/1924
20 UNDERTAKER	ADDRESS
E. D. Fanning & Son - 1938 E.	Lafayette Ave.

MAGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83351

HEALTH DEPARTMENT—CITY OF BALTIMORE.

100 D 83351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Bruce ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Holora Washington

(a) RESIDENCE No. 720 Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Morel Washington

11 BIRTHPLACE OF FATHER (city or town) Essex Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Holora Reed

13 BIRTHPLACE OF MOTHER (city or town) Middlesex Co (State or country) Virginia

14 Informant Wm. Reed

(Address) 718 Bruce St

15 Filed Feb 2 1924 Robert F. Marriott, Registrar

Burial Permit Clerk.

B 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1924, to Feb 1, 1924, that I last saw her alive on Jan 31, 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank L Saunders, M. D.

, 19 (Address) 1128 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Auburn	Feb 2 1924
20 UNDERTAKER	ADDRESS
Chas W. Chase & Son	1401 Mar... St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONSULTATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83352

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital 25 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Casey

(a) RESIDENCE No. 1223 Maiden ST., Mt Winans WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital

15 B 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febr. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from February 5, 1924 to February 1, 1924, that I last saw him alive on Febr. 1, 1924, and that death occurred, on the date stated above, at 4.15 p. m.

The CAUSE OF DEATH* was as follows:

General Paralysis
Luetic Infekt.

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Term. Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic & Lab.

(Signed) N. B. Clement, M. D.

, 19 (Address) 1707 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Granite Balto Co

DATE OF BURIAL July 1 1924

20 UNDERTAKER John Ulrich

ADDRESS 2008 Aisquith

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

132

D 83353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital 21 ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Stansbury

(a) RESIDENCE No. 1029 Ridgley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Stansbury

6 DATE OF BIRTH (month, day, and year) March 4 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer City Hall

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Comelia Purpur

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto.

14 Informant Alice Stansbury

(Address) 1029 Ridgley St

15 Filed FEB 2 - 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31- 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-28- 1924, to 1-31- 1924,

that I last saw him alive on 1-31- 1924

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Renal & uretural Calculi

(duration) ?, yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation Shock

(duration) yrs. mos. 2 hrs dr.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-31-24

Was there an autopsy? Yes

What test confirmed diagnosis? Operative findings

(Signed) H. L. Barr, M. D.

1/31/ 1924 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Feb 4 1924

20 UNDERTAKER E. Kelly Lowe Son — ADDRESS 1039 Hanover

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83354

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001 D 83354

Registered No.....

City of BALTIMORE: (No. 534 Arlington Ave (Govans) St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Ritzius Reese

(a) Residence No. 534 Arlington Ave (Govans) St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: W.

5-~~Single, Married,~~ Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Reese

6-DATE OF BIRTH (month, day and year) May 27th, 1840

7-AGE: 83 yrs. 8 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Gelnhausen, Hesse Germany

PARENTS.

10-NAME OF FATHER: John Justus Ritzius

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Anna Katherine Beyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11-
(Informant): Miss Mary Reese
(Address): 534 Arlington Ave (Govans)

15-
Filed ..... 192.....
Robert P. Harrison, Registrar.

FEB 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 31st, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1924 to Jan 31 1924
that I last saw h[illegible] alive on Jan 30 1924
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

Contusion Lungs
Chron Interstitial Nephritis
Chron Myocarditis
(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage
(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings- H.K. Ostes

(Signed) S. L. Bishop, M. D.
Feb 1, 1924 (Address) 50 Sheridan Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cemetery	Feb 4th, 1924
20-UNDERTAKER, Putnam & Gore	ADDRESS 1723 W Lafayette Ave

NOTE—Entries must be typewritten or printed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY, if known, otherwise APPROXIMATELY. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83355

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 South Bouldin St., ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Heinze

(a) RESIDENCE. NO. 502 South Bouldin St., ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Heinze

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	81	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schatz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth F. Gibbs,
(Address) 508 South Bouldin St.,

15 Filed ....., 19.. Robert P. Harrison, Registrar

EB 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1923, to Jan 30, 1924, that I last saw her alive on Jan 29, 1924, and that death occurred, on the date stated above, at 11.50 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Murm. Heart Arrest

(Signed) D. Strauber, M. D.

, 19 (Address) 3015 Elmwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	Feb 2, 1924
20 UNDERTAKER	**ADDRESS**
H. Sander & Sons	1710 Fleet St

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83356

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 83356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 520 N. Streeper St

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdelina Annie Shaefer

(a) RESIDENCE NO. 520 N. Streeper ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 30 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced (or) WIFE of Joseph Conrad Shaefer

6 DATE OF BIRTH (month, day, and year) May 1, 1860

7 AGE — Years 63 — Months 8 — Days 30 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore MD.

PARENTS

10 NAME OF FATHER Michael A. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wolfram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) William Edward 520 N. Streeper St

15 Robert P. Harrison, 19 .....
Burial Permit Clerk. Registrar

B 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1924, to Jan 31, 1924.

That I last saw h[illegible] alive on Jan 31, 1924;

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

2 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Dobihal, M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Mrs C. Miller — ADDRESS 2334 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83357

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 83357

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Bartlett Ave ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin J. Croghan

(a) RESIDENCE NO. 606 Bartlett Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Croghan

6 DATE OF BIRTH (Month and year) January 10/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min:
	52	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Lo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Croghan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. John Croghan
(Address) 606 Bartlett Ave

15 Filed FEB 2 1924, 19.....
Robert T. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) February 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31st, 1924, to Feb 1st, 1924.

that I last saw h[illegible] alive on Feb 1st 1924,

and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wolfgang Stopnicka M. D.

2/1/1924 (Address) 404 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph, Texas Balto | DATE OF BURIAL Feb 4 1924

20 UNDERTAKER E. A. Weidefeld Jr. | ADDRESS 5 N Bar

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83358

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 E 21st St., 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Roddy,

(a) RESIDENCE NO. 705 E 21st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle Roddy

6 DATE OF BIRTH (month, day, and year) Aug. 24 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cafe. Owner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard Roddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Susan Roddy 705 E 21st St

15 Filed FEB 2 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2 1923, to Feb. 1 1924, that I last saw him alive on Jan. 31 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Hyleris-Sclerosis - Cardiac Hypertrophy - Chronic nefritis

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? mental examination

(Signed) Benj. D. Hayden, M. D.

2/2 1924 (Address) 1216 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb 4 1924

20 UNDERTAKER E A Wedefeld

ADDRESS 501 E 22

FEB 2 1924

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83359

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 North Stricker ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wyndham Robertson Blackford

(a) RESIDENCE NO. 233 N Stricker St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Alice Blackford

6 DATE OF BIRTH (month, day, and year) Aug. 8- 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) ~ 066

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Va

PARENTS

10 NAME OF FATHER Wm W. Blackford

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Alice T. Blackford

(Address) 233 N. Stricker St

15 Filed ....., 19.... Robert P. Harrison, Registrar

FEB 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1923, to Feb 2nd, 1924,

that I last saw him alive on Feb 1st, 1924

and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

Cardiac Dilatation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) X Parenchymatous Nephritis (duration) one yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (No TB)

(Signed) Bernard L. French, M. D.

, 19 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alexandria Va.	2/4 1924
20 UNDERTAKER	ADDRESS
Geo. J. Smith	1532 Hollins St

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic

Cor.—1-12-23—M&T—100 Bks.

D 83360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83360

CERTIFICATE OF DEATH.

101-60

1-PLACE OF DEATH

Pronounced dead at

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A. Leake

(a) RESIDENCE No 1024 Hillen St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred // yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Leake

6 DATE OF BIRTH (month, day, and year) April 4/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	09	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rockingham N.C.

PARENTS

10 NAME OF FATHER George Leake

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mollie Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mary Leake
(Address) 1024 Hillen Street, ~~Robert P. Hatton,~~

15 FEB 2 Filed 1924 192 Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Probably Lobar Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

(Signed) J. S. Collins, M. D. (Coroner.)

Jan 31/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockingham N.C.

DATE OF BURIAL Feb 2 1924

20 UNDERTAKER John W Henderson

ADDRESS 1502 E mount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83361

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Rutland Ave ST.: 8 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Foos.

(a) RESIDENCE. No. 1113 Rutland Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Necker

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) 011

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Foos

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fanny St. Clair

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant (Address) Miss Mary Ann Foos 1113 Rutland Ave.

Filed FEB 2 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to January 30, 1924, that I last saw h in alive on January 30, 1924, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Feb 1, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	2/4 1924
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83362

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00D 83362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth's Home Chemt Hague ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Benson

(a) RESIDENCE. No. St. Elizabeth's Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	negro	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Benson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant
(Address)

15 Filed FEB 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from November, 1923, to January 31, 1924, that I last saw him alive on January 31, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Feb. 1, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	FEB 2-1924
20 UNDERTAKER (Commissioner of Health.)	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83363

CERTIFICATE OF DEATH.

129 D 83363

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Louise T. Rhein, St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Superior of Sem. Conv,

(a) Residence No. Pulaski Valley St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. old

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Catonsville Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Theodore Rhein

11-BIRTHPLACE OF FATHER (city or town). (State or Country).

12-MAIDEN NAME OF MOTHER, Ottilia Furst.

13-BIRTHPLACE OF MOTHER (city or town). (State or Country).

14-

(Informant) Sister Florence

(Address) Loudon Park Sta.

15-

Filed ..... 192 ..... Clerk.

FEB 2 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1 1924

17- I HEREBY CERTIFY, That I attended deceased from No Record 19.. to 19..

that I last saw h.. alive on 19 24

and that death occurred, on the date stated above, at. 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Jan 1 (Signed) F. A. Warner M. D

, 19 24 (Address) 1130 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Melchester	Feb 4, 1924
20-UNDERTAKER,	ADDRESS
H. C. Wedefield	914 Fremont Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83364

CERTIFICATE OF DEATH.

160

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E Castle ST., V WARD)

2-FULL NAME Baby Beran

(a) RESIDENCE NO. 16 E Castle ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Feb 1 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman J Beran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carolina

14 Informant Herman J Beran
(Address) 16 E Castle St

15 Filed FEB 2 1924 Robert A. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1924, to Feb 1 1924, that I last saw h.r alive on Feb 1 1924, and that death occurred, on the date stated above, at 6 40 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility.

Prolonged Labor. Breech Extraction

(duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C H Meyer Jr M. D.

2/2, 1924 (Address) 1131 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 19

20 UNDERTAKER Kendall & Pippel — ADDRESS 3 E Lanvale

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83365 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83365

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 Peach St. WARD 23)

2-FULL NAME Jamie Jasmell

(a) RESIDENCE No. 927 Peach St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Jasmell

6 DATE OF BIRTH (month, day, and year) ——— 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) "Eastern Shore"
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Caroline ———

13 BIRTHPLACE OF MOTHER (city or town) "Eastern Shore"
(State or country) Maryland.

14 Informant Robert Jasmell
(Address) 927 Peach St

15 Robert P. Harrison, 19.....
Registrar
Burial Permit Clerk.

B 2 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to Jan, 31, 1924, that I last saw her alive on Jan, 31, 1924, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm Francis, M. D.

2/1, 1924 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~LAERA~~ Laurel Cem — DATE OF BURIAL Fe 4 1924

20 UNDERTAKER R L .PARHAM — ADDRESS 902 leadenhall st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K 00 D

D 83366 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 83366

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 911 N. Calhoun St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Miles

(Residence in Baltimore: No. 911 N. Calhoun St. St.; 44 yrs. 5 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: July 12, 1880 (Month) (Day) (Year)

7-AGE: 44 yrs. 5 mos. 18 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Jacob Ringold

11-BIRTHPLACE OF FATHER, (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Sophia French

13-BIRTHPLACE OF MOTHER, (State or Country): Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elodus Miles

(Address) 911 N. Calhoun St.

15-

FILED FEB 3 - 1924

ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 30, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endometritis
(uterine curettement)

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Ether Anesthesia 20 minutes

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Feb 2 1924 (Address) 2802 Edmondson Ave.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery | DATE OF BURIAL, Feb. 7, 1924

20-UNDERTAKER, Mrs. Katie R. Williams | ADDRESS 322 N. Schroeder St.

N. B.—Every item of information should be carefully supplied. AGE must be given. Exact statement of OCCUPATION is very important. See instructions on back of certificate. state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83367 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 83367
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 1127 E. Lombard St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Goldman

(a) Residence No 1127 E. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. 4 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 7 1923

7-AGE, ...yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER Samuel Goldman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Roumania

12-MAIDEN NAME OF MOTHER, Ella Friedman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Samuel Goldman

(Address) 1127 E. Lombard st

15- Filed ..... 19?.....

ROBERT R. KRAUTER, Registrar.

FEB 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/2/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1924 to Feb 2nd 1924

that I last saw him alive on Feb 2nd 1924

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia 11 24

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) H Hanstein

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

2/2, 1924 (Signed) Harry Goldberg M. D.

(Address) 2210 Gustavus pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Fairview Herring Run

DATE OF BURIAL, Feb 3 1924

20-UNDERTAKER, Sol Grunsfeld & Bro

ADDRESS 1127 E. Balto st

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Primary

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 83368 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 37 Lloyd St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Rehman

(a) Residence No. 37 Lloyd St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Hirsh Schwartz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Dora Krantz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Moses Schwartz

(Address) 37 Lloyd St

15- Filed FEB 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 1/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 19 24 to Feb 2 19 24

that I last saw h.. alive on Feb 2 19 24

and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

Feb 3, 19 24 (Address) 1100 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Feb 3 19 24

20-UNDERTAKER, Sol Levinson & Bro — ADDRESS 1127 E Baltimore St

IMPORTANT. PHYSICIANS should be stated EXACTLY. PHRASING should be plain and unqualified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Corr.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83369

CERTIFICATE OF DEATH.

D 83369

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 N. High St., 5 WARD)

2-FULL NAME Catherine Kilroy

(a) RESIDENCE No. 231 N. High ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Kilroy

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Cusick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Deaf Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Katie Barnes (Address): 413 N. Wright St

15 Filed FEB 3 - 1924 ROBERT M. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro Embolism

Duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmo. Edema

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

Jan 1, 192 4 (Address) 1632 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Josephs, Texas. md

DATE OF BURIAL: Feb 4 192 4

20 UNDERTAKER: [illegible]

ADDRESS

CAUSE OF DEATH MAY be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83370

CERTIFICATE OF DEATH.

13 D 83370

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2105 Greenmount St., Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Easey

(a) Residence No. 2105 Greenmount St. Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ella Easy

6-DATE OF BIRTH (month, day and year) Jan 1-1849

7-AGE, 75 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk 809

(b) General nature of industry, business, or establishment in which employed (or employer) Bath (Public)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER William Easey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Jane Ward

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Ella Easey

(Address) 2105 Greenmount Ave

15-

FEB 3 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 2. 1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 21, 1924 to Feby 2, 1924, that I last saw h.[illegible] alive on Feby 2, 1924, and that death occurred, on the date stated above, at 4.25 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (right lung)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Parolitis (Edema Lungs)

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 1246 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery

DATE OF BURIAL, Feb 4th 1924

20-UNDERTAKER. William Cook

ADDRESS 507 E North Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Sandreson - 1714 N. Caroline.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83371

CERTIFICATE OF DEATH.

101-001 D 83371

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1505 E. Lafayette Ave St. 8 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Vera Violet Lusby

(a) Residence No. 1505 E. Lafayette Ave St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1 1887

7-AGE. 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer). do

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. William Lusby

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Emma Saunders Ham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14-

(Informant) Mary R. Lusby

(Address) 505 E. Lafayette Ave

15-

FILED FEB 3 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 27, 19 24 to Feb 1, 19 24

that I last saw h[illegible] alive on Jan 1, 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G. Sanderson M. D

, 19 (Address) 1714 Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. Feb. 7, 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E North Ave.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83372

CERTIFICATE OF DEATH.

57 D 83372

REGISTERED NO. C.....

1-PLACE OF DEATH Southern Hospital.

CITY OF BALTIMORE: (No. 2520 Monument Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella Kemp

(Residence in Baltimore: No. 3102 d. Lanvale St St. Life yrs.....mos.....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, Widow OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Dec 31 1843, 1 (Month) (Day) (Year)

7-AGE, 80 yrs. 11 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... NO

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard L. Kemp

(Address) 1111 Falls Road

15- Filed FEB 3 - 1924, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 1-, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 14 1923, to Feb. 1- 1924, that I saw h-r alive on Feb. 1- 1924, and that death occurred, on the date stated above, at 7-0 A. m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans,

(Duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(Duration) 2 yrs. - mos. 1 ds.

(Signed) Dudley P. Bowe M. D.

Feb 1-, 1924 (Address) 904 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb. 4, 1924

20-UNDERTAKER Wm. Leos — ADDRESS 502 E Main

Spec.—3-10-21—M&T—1500 Bks.

D 83373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83373

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Winchester ST., 16 WARD)

2-FULL NAME Mrs. Maria Fredrick Mrozoff

(a) RESIDENCE NO. 2914 Winchester ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of John J. Mrozoff

6 DATE OF BIRTH (month, day, and year) June 5th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59 yrs.	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~ None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Frdnck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Interment (Address) Mrs Maria Mrozoff 2914 Winchester

15 FEB 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1924, to Feb. 1, 1924.

that I last saw her alive on Feb. 1, 1924

and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Lab.

(Signed) Homer C. Todd, M. D.

2/2, 1924 (Address) 735 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine County — DATE OF BURIAL 2/4 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Nath

ration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83374

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1611 Harlem Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Estelle Ball

(a) Residence No. 1611 Harlem Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, Married or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William E.

6-DATE OF BIRTH (month, day and year) May 30 1875

7-AGE. 48 yrs. 8 mos. 1 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Balto

PARENTS.

10-NAME OF FATHER John O Schafer

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Germany

12-MAIDEN NAME OF MOTHER Caroline Barnecke

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Baltimore

11- (Informant) William Ball

(Address) 1611 Harlem Ave.

15- FEB 3 - 1924 ROBERT R. KRAUS Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 26 19 24 to Feby 1 19 24

that I last saw h.. alive on Jany 31 19 24

and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchites Chronic

(Duration) 2 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ~ yrs. ~ mos. ~ ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Shannon M. D

1/1 1924 (Address) 700 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn DATE OF BURIAL, Feb 4 1924

20-UNDERTAKER. Wm Cook ADDRESS 5022 Harford Ave

SHOULD BE EXACTLY FURNISHED. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83375

CERTIFICATE OF DEATH.

10 D 83375

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., L. WARD)

2-FULL NAME Charles H. Myers.

(a) RESIDENCE NO. 603 S. Linwood ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May 2 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore. (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Myers.

11 BIRTHPLACE OF FATHER (city or town) Baltimore. (State or country) Md.

12 MAIDEN NAME OF MOTHER Christine Wurl 2/2/24

13 BIRTHPLACE OF MOTHER (city or town) Baltimore. (State or country) Md.

14 Informant Charles Myers.

(Address) 603 S. Linwood Ave.

15 Filed FEB 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1924, to Feb 2, 1924.

that I last saw him alive on Feb 2, 1924,

and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal & nasal

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) bronchopneumonia

(duration) — yrs. — mos. 4 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? culture (+)

(Signed) B. MacLaren, M. D.

(Address) Sydenham Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Paul's Meml. Cem.	Feb. 3 1924.
20 UNDERTAKER Lilly & Gaither.	ADDRESS 903 W. Fay. St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83376

CERTIFICATE OF DEATH. X 129 ✓ D 83376

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Perry Cotrill

(a) RESIDENCE NO. Richwood, W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	47	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Forester 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrison Co., W. Va.

PARENTS

10 NAME OF FATHER Wm. Cotrill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrison Co., W. Va.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Braxton Co., W. Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed FEB 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1924, to Feb. 2, 1924, that I last saw h. alive on Feb. 2, 1924, and that death occurred, on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? W. Va.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Erbacon W Va

DATE OF BURIAL 2/3 1924

20 UNDERTAKER Jack Lewis 1439 E Balt St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83377

CERTIFICATE OF DEATH.

117

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Bals Gen'l Hosp ST. 27 WARD)

2-FULL NAME Louis Abramowitz

(a) RESIDENCE NO. 1768 Pendleton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 23 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND (or) WIFE of Dora Abramowitz

6 DATE OF BIRTH (month, day, and year) September

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer) 080
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Baltimore St.

FEB 3 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1 1924

17 I HEREBY CERTIFY, That I attended deceased from January 27, 1924, to February 1, 1924
that I last saw him alive on February 1, 1924
and that death occurred, on the date stated above, at 10.45 P m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of January 27/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A J Lloyd, M. D.

, 19 (Address) 2232 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Rosedale	2/3 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

N.B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83378

CERTIFICATE OF DEATH.

111-005 D 83378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Maltzer

(a) RESIDENCE No. 1631 Moreland Ave ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Rose Maltzer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

Filed FEB 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1 - 1924

17

I HEREBY CERTIFY, That I attended deceased from January 25, 1924, to February 1, 1924, that I last saw him alive on February 1 - 1924, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer (Perforated)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cerebritis (Embolic)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan 26 -

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Jerome H. Wilkinson, M. D.

19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Feb 3 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mattie Ray Stiffler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83379 ✓ 101-0D 83379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. 14 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Ray Stiffler

(a) RESIDENCE NO. Freeland, Balto. Co., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-8-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Guy W. Calp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Emma L. Stiffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Guy W. Calp

(Address) Freeland Md.

15 Filed ....., 19 .... ROBERT R. KRAUTER Registrar

FEB 3 - 1925 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2-1924

17

I HEREBY CERTIFY, That I attended deceased from 2-1-, 1924, to 2-2-, 1924, that I last saw h[illegible] alive on 2-2-, 1924 and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(5 mos ago.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema L. Apex

(duration) from birth yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2-2-24

Was there an autopsy? no

What test confirmed diagnosis? Clin. findings

(Signed) N. J. Parr, M. D.

2/4, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL H. Abrahams (Fresh Pond) Balto Co Md

DATE OF BURIAL 2/5 1924

20 UNDERTAKER W. J. Tickner & Son Pulaski

ADDRESS Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Keyser

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83380

CERTIFICATE OF DEATH.

57 D 83380

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4008 Gwinnett Ave. ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen E Keyser

(Residence in Baltimore: No. 4008 Gwinnett Ave St.; 58 yrs., 5 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widowed

6-DATE OF BIRTH, August 22, 1865 (Month) (Day) (Year)

7-AGE, 58 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Thomas Mountgarrity

11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Elizabeth Carmical Walker

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George F Keyser

(Address) 4008 Gwynn Oak Ave

FEB 3 - 1924 ROBERT R. KRAUTER, 191..... Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1923, to July 2 1924 that I saw h-- alive on July 1 1924 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) 6 yrs. — mos. — ds.

(Signed) D Kaufman M. D.

2/3, 1924 (Address) 1340 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, Feby 4, 1924

20-UNDERTAKER Harry M. Armacost — ADDRESS 4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83381

CERTIFICATE OF DEATH.

31 D 83381

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Rectory Lane ST., 13 WARD)

2-FULL NAME George Howard Rankin Turnbaugh

(a) RESIDENCE No. 1005 Rectory Lane ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise E. Turnbaugh

6 DATE OF BIRTH (month, day, and year) March 18-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk R.R. Express Co.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Melchior Turnbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Cullings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Louise E. Turnbaugh

(Address) 1005 Rectory Lane

FEB 3 - 1924 Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to Feb 1, 1924

that I last saw him alive on Feb 1, 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Clinical

(Signed) Harry C. Algire, M. D.

Feb 1, 1924 (Address) 3640 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys (Hampden)	Feb. 5 1924
UNDERTAKER	ADDRESS
Horace H. Burgee	363 Falls Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83382

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D 83382

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3625 Roland Ave ST., 13 WARD)

2-FULL NAME Mark Harris Thompson

(a) RESIDENCE NO. 3625 Roland Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Thompson

6 DATE OF BIRTH (month, day, and year): Jan. 8-1857

7 AGE: Years 67 | Months — | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tool maker

(b) General nature of industry, business, or establishment in which employed (or employer): Murrill, Keiser Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: Robert Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Katherine Kidd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Edith E. Thompson

(Address): 3625 Roland Ave

15 Filed FEB 3 - 1924, 19 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1922, to Jan 31, 1924, that I last saw h[illegible] alive on Jan 31, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Cerebral Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Blood Examination Microscope

(Signed) Harry C. Alpert, M. D.

Jan 31 1924 (Address) 3640 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb. 4, 1924

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83383 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-01 ✓ D 83383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 McEldry ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Foeller Jr

(a) RESIDENCE NO. 1623 McEldry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Mary A Foeller

6 DATE OF BIRTH (month, day, and year) Jan 19-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Emp. by City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Caspar Foeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catharine Foeller (Address) 1623 McElderry St

15 Filed FEB 3 - 1924 16 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1923, to Jan 31, 1924, that I last saw him alive on Jan 31, 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. 5 mos. 10 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) E B Mittow M. D.

, 19 (Address) 1711 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cem. DATE OF BURIAL 2/4 1924

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1694 D 83384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 | D 83384

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Pinkney

(a) RESIDENCE No. 628 Gold St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Pinkney

6 DATE OF BIRTH (month, day, and year) Unknown - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER C A Giles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Jan 30, 1924

that I last saw him alive on Jan 30, 1924,

and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Rheumatic Endocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) R. R. Krauter, M. D.

1/31, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem.

DATE OF BURIAL 2/2 1924

20 UNDERTAKER Samuel J Wensley

ADDRESS W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83385

CERTIFICATE OF DEATH.

74-001

Overlea

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belair Road opposite Kenwood Ave ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Quick

(a) RESIDENCE No. Belair Road opp. Kenwood Ave ST., Overlea WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Quick

6 DATE OF BIRTH (month, day, and year) April 19th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) Home Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Peter Quick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Roessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Quick (Address) Overlea Md.

15 Filed FEB 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1924 to Feb 1st 1924

that I last saw h— alive on Feb 1st 1924

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 11½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Paralysis & onset

(Signed) Edw. H. Benson, M. D.

Feb 2 1924 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Feb 5 1924

20 UNDERTAKER Fred Lasch & Sons — ADDRESS Fullerton

IMPORTANT—INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83386 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 74-001 ✓ D 83386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 ; Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hayes Thompson

(a) Residence No. ~~Penn Road St Roseberg, Md~~ Chestnut Ave & Belair Rd Overlea St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE. White | 5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 64 yrs. — mos. — ds. | If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Laundry 041
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Havre de Grace Md.

PARENTS

10-NAME OF FATHER. Charles Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Matilda Whitaker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland.

14- (Informant) John E. Rank
(Address) Overlea Md.

15-
FEB 3 - 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1922 to February 2 1924 that I last saw him alive on February 2 1924, and that death occurred, on the date stated above, at 11-15 A. M. The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. 6 hours mos. ds.

CONTRIBUTORY (Secondary) Generalized Arteriosclerosis

(Duration) 1 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Fulton M. D

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery | DATE OF BURIAL, Feb. 5th, 1924

20-UNDERTAKER. Fredk Lassahn & Sons | ADDRESS Fullerton

SHOULD BE EXACTLY: PHYSICIANS should be careful. AGE should be stated EXACTLY. Should be carefully supplied. AGE should be stated EXACTLY. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83387

CERTIFICATE OF DEATH.

D 83387
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5000 Harford Road ST., Lauraville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius W. Knox

(a) RESIDENCE NO. 5000 Harford Road ST., Lauraville WARD
(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia C. Knox

6 DATE OF BIRTH (month, day, and year) July 15th 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Knox

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant William Knox
(Address) 5000 Harford Road Lauraville

15 FEB 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from April 5 1923 to Feby 1 1924.

that I last saw him alive on Feby 1 1924

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) — yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

2/2. 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Feb. 4 1924

20 UNDERTAKER Fredk Lasselman Sons

ADDRESS Pikesville

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83388

CERTIFICATE OF DEATH.

11-00 D 83388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2141 W Fayette ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm N. Conner

(a) RESIDENCE No. 2141 W Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Marian Conner

6 DATE OF BIRTH (month, day, and year) Feby 11, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer): ✓ 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chambersburg Pa

PARENTS

10 NAME OF FATHER: Nelson P. Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Leesburg Va

12 MAIDEN NAME OF MOTHER: Elizabeth Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robt M. Conner

(Address): 5004 Elmer Ave

15 FEB 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 23, 1924, to Feby 1, 1924, that I last saw him alive on Jany 31, 1924, and that death occurred, on the date stated above, at 7:10 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. Weisse M. D.

, 19 24 (Address) 108 N Bolton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Feb. 4 1924

20 UNDERTAKER: Margaret A. Flynn — ADDRESS: [illegible] Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Ida Singer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83389

CERTIFICATE OF DEATH.

14-009 D 83389

1-PLACE OF DEATH Balto and Payson Sts

REGISTERED NO.

CITY OF BALTIMORE: (No. German Aged Home St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Singer

(a) RESIDENCE. No. German Aged St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Singer

6 DATE OF BIRTH (month, day, and year): May 6, 1850

7 AGE: Years 73; Months 8; Days 24; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: German Aged Home Records

(Address): Balto and Payson Sts

15 FEB 3 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 16th. 1924, to Feb. 1st 1924, that I last saw h ee alive on Jan 31st. 1924, and that death occurred, on the date stated above, at 8.30a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 14. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John Houff, M. D.

19 (Address) 1848 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Feb 4 24

20 UNDERTAKER: Joseph. B Cook — ADDRESS: 1003 W. Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83390

CERTIFICATE OF DEATH.

90 D 83390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Covington ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Schaedler

(a) RESIDENCE NO. 1411 Covington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ (or) WIFE of Adolph Schaedler

6 DATE OF BIRTH (month, day, and year) April 4th 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. John Dietrich

(Address) 1411 Covington St

15 FEB 4 - 1924 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1924

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924 to Jan 31, 1924

that I last saw h[illegible] alive on Jan 31, 1924

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schenuck M. D.

, 19 (Address) 119 E. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. A. Co. — DATE OF BURIAL 1-4 1924

20 UNDERTAKER E & I Harle 115 E West St — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83391

CERTIFICATE OF DEATH.

11-800 B 83391

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 W. Henrietta ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Pitts

(Residence in Baltimore: No. 143 W. Henrietta St.; 21 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, ... (Month) Not known (Day) ..... 1864 (Year)

7-AGE, 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... Of

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Saml. Pitts

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Betsy Crossfield

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Maggie Jones

(Address)..... 143 W. Henrietta St

15- FEB 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan. (Month) 31 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1924, to Jan. 31, 1924, that I saw h.. alive on Jan. 31, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

..... Grip .....

.....

.....

..... (Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

..... (Duration) .....yrs. .....mos. 1 ds.

(Signed) ..... J. T. Hammett M. D.

Feb. 1, 1924 (Address) 2126 Madison Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Feb. 4, 1924

20-UNDERTAKER A. L. Bloom & Son ADDRESS 1618 W. Monument

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83392

CERTIFICATE OF DEATH.

90 D 83392

1-PLACE OF DEATH

City of BALTIMORE: (No. 889 West Fayette St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Veasel

(a) Residence No. 889 West Fayette St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Veasel

6-DATE OF BIRTH (month, day and year) June 7-1856

7-AGE, ... 67 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Thos. M. Duncan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Sarah E Duncan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Wm H. Veasel

(Address) 889 W Fayette

FEB 4 - 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 19 24 to Feb 2 19 24

that I last saw h..... alive on Feb 2 19 24

and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 6 hrs ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) C. H. Woodward, M. D.

Feb 3, 19 24 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, 2/5/24 19..

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83393

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Volunteers of America Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 418 N. Lexington St. ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V. Massieu

(a) RESIDENCE. No. 1506 N. Gilmore ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER John Massieu

11 BIRTHPLACE OF FATHER (city or town) Phila, Pa.
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Georgine Almstedt
(State or country) Va

14 Informant Julius Massieu
(Address) 1539 N. Gilmore

15 Filed FEB 4 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3- 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1924, to Feb. 3 1924,
that I last saw h[illegible] alive on Feb. 2, 1924,
and that death occurred, on the date stated above, at 2:40 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Few yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. R. Johnson, M. D.

2/3, 1924 (Address) 1210 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park, Feb. 5	1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E. Monroe

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83394

CERTIFICATE OF DEATH.

3 / D 83394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 962 N. Chapel ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kozta

(a) RESIDENCE NO. 962 N. Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20 yrs	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Rokta

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Czechoslovakia

12 MAIDEN NAME OF MOTHER Josephine Benedicka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Czechoslovakia

14 Informant Josephine Rokta
(Address) 962 N. Chapel St

15 Filed FEB 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1924, to Feb. 3, 1924, that I last saw her alive on Feb. 3, 1924, and that death occurred, on the date stated above, at 6 50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Joska, M. D.

19 (Address) 845 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb. 6 1924

20 UNDERTAKER: Edward Enoch & Son — ADDRESS: 1116 Carlton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83395

100-901

D 83395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 914 Ramsay St. 21 Ward)

2-FULL NAME Mildred D Umfreid UNFREID.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 914 Ramsay St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 8. 1922

7-AGE. 1 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. D. M. Umfreid

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER. Elsie Ulrich

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14-(Informant) D. M. Umfreid

(Address) 914 Ramsay St

15-FEB 4 - 1924 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 1/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 29 24 to Feb 1 24, 19..

that I last saw h alive on Feb 1 24, 19..

and that death occurred, on the date stated above, at 8.55 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted, if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. G. Schumann M. D.

Feb 2. 1924 (Address) 1100 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parkwood	Feb 4 1924
20-UNDERTAKER.	ADDRESS
Jno. Mus. J. W. Teufel & Son	801 W. Fayette

Should be carefully supplied. Acts should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 - M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83396

CERTIFICATE OF DEATH.

114 D 83396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Division ST., 14th WARD)

2-FULL NAME Mattie J. Sane

(a) RESIDENCE NO. 1607 Division ST., 14th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If ~~married~~ widowed, ~~or divorced~~ HUSBAND of (or) WIFE of George M. Sane

6 DATE OF BIRTH (month, day, and year) August 20, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	53	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (C.K. J. T. Kenney) 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex County (State or country) Virginia

PARENTS

10 NAME OF FATHER Carter Nelson

11 BIRTHPLACE OF FATHER (city or town) Essex Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Marcella Pitts

13 BIRTHPLACE OF MOTHER (city or town) Essex Co. (State or country) Virginia

14 Informant E. Everett Sane (son) (Address) 1607 Division St.

15 FEB 4 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29-1924

17 I HEREBY CERTIFY, That I attended deceased from January 29, 1924, 10 P.m. to January 29, 1924, 11:20 P.m. that I last saw him alive on January 27, 1924, and that death occurred, on the date stated above, at 11:20 P.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart (Acute gastro enteritis) Indigestion of duration of dis. 7 days

CONTRIBUTORY (Secondary) Kidney Infection (duration) 1 yrs. mos. 3 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. LeRoy Barnes, M. D.

1-30, 1924 (Address) 1219 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Feb. 4th 1924

20 UNDERTAKER Jno. M. Johnson — ADDRESS 1309 Druid Hill Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

83397 — CERTIFICATE OF DEATH. — 100 D 83397

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1615 Park Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Welch

(a) Residence No. 1615 Park Ave St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) April 1 1849.

7-AGE 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Welch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11- (Informant) Records of Baptist Home

(Address) 1615 Park Ave

15- Filed FEB 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 23 1924 to Feb. 1 1924, that I last saw her alive on Jan. 31 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) A. F. Robinson M. D

2/2, 1924 (Address) 1307 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery — DATE OF BURIAL, Feb 4 1924

20-UNDERTAKER, John A. Mitchell — ADDRESS 1201 W. Fayette St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83398

CERTIFICATE OF DEATH.

129 D 83398

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2580 Druid Park Drive St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Truehart

(a) Residence No. 2580 Druid Park Drive St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy A. White

6-DATE OF BIRTH (month, day and year) Oct 15 1835

7-AGE, 88 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), na.

PARENTS.

10-NAME OF FATHER, Wm. S. Truehart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), na.

12-MAIDEN NAME OF MOTHER, Rebecca Southall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), na.

14- (Informant) Chas. W. Truehart

(Address) 3022 N. Calvert St.

15-

Filed ....., 19?

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923, to Feb 2, 1924 that I last saw him alive on Feb 2, 1924, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ....

(Signed) H. H. Warner, M. D.

, 19 (Address) 1604 Garrison Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Feb 4 19 24

20-UNDERTAKER, John Ottitchell — ADDRESS 1201 W. Fayette St.

SHOULD BE CAREFULLY EXAMINED AND THE CAUSE OF DEATH certified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 N. Gilmor St., 9 WARD)

2-FULL NAME John S. Schweinberg

(a) RESIDENCE NO. 1602 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

1-9 D 83399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

GE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Schweinberg

6 DATE OF BIRTH (month, day, and year) May 12 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor. 060

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Stefan Schweinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Gotlieb Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Sophia Schweinberg

(Address) 1602 N. Gilmor St

15

FEB 4 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 27, 1924, to Jan 30, 1924

that I last saw him alive on Jan 30, 1924

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

acute Nephritis

(duration) 6 wks. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Anderson, M. D.

, 19 (Address) 1748 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemtery.	Feb 4 1924
20 UNDERTAKER	ADDRESS
Geo. L. Rust	1735 Hanford Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer. Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Stomach Poisoning from
eating ~~some food~~
Investigated by Dr. Calla
Coroner & found the Man
died from Chr Nephritis
Several years duration

Spec.—1-10-21—M&T—1500 Blks.

Tillman

D 83400 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D 83400

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hosp 27

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Tillman

(a) RESIDENCE NO. 5 542 Welcome Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not obtained

6 DATE OF BIRTH (month, day, and year) Not obtained

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 40

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store.

(c) Name of employer C.D. Kenney.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elmer Tillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Allen.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records Transcript (Address)

FEB 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1/1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1924, to ....., 19....., that I last saw h alive on 2/1/24, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Ventricular fibrillation
with acute dilatation of heart
and pulmonary edema
Uncertain (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilis bronchopneumonia
Bronchopneumonia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Feb 4 1924
20 UNDERTAKER John H Toadvine	ADDRESS 142 Ostend St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83401

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. 12 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Weber

(a) RESIDENCE NO. Pikesville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER George Weber

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Florence Keller

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. George Keller
(Address) Pikesville Md.

15 Filed FEB 4 - 1924, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1924, to Feb. 3, 1924, that I last saw her alive on Feb. 3, 1924, and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Empyema

Unresolved pneumonia

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

Otitis media Bilateral (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1/6/24

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb 4 1924
20 UNDERTAKER J. F. Elvis	ADDRESS Reisterstown Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83402

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 Forest Road ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mable Streett Earle

(a) RESIDENCE No. 317 Forest Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Swepson Earle

6 DATE OF BIRTH (month, day, and year) June 6th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	45	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel air

(State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER Jos. M. Streett

11 BIRTHPLACE OF FATHER (city or town) Near Bush River

(State or country) Harford Co. Maryland

12 MAIDEN NAME OF MOTHER Juliet Gover

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14

Informant Jos. S. Jacob

(Address) 317 Forest rd. Roland Park

15

Filed FEB 4 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 29 1924 to Feb 2 1924,

that I last saw her alive on Feb 2, 12 midnight 1924,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic -

Adenoma, Primary -

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical etc

(Signed) J. Colby Streett, M. D.

, 19 (Address) 711 Park Ave, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Spring Belair Md

DATE OF BURIAL Feb 5th 1924

20 UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS Richardson & Cullen

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83403 HEALTH DEPARTMENT—CITY OF BALTIMORE 100 001 D 83403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alex. Michael Grineiviski

(a) Residence No. ~~Unknown~~ 240 S. Bond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1868

7-AGE. 56 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.
10-NAME OF FATHER, ?
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

11- (Informant) Municipal Hospital Records
(Address)

15- Filed FEB 4 - 1924 16- ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 3, 19 24 to February 1 19 24 that I last saw him alive on February 1, 19 24 and that death occurred, on the date stated above, at 19:15 A.M

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Emphysema
Chronic Bronchitis
(Duration) 1 yrs. (Hours) ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia
(Immed.) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Evans, M. D
2-2-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Feb. 4, 1924
20-UNDERTAKER, Lamm & Zubkus	ADDRESS 425 S. Paca St.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 83404

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 Parkin ST.: 18 WARD)

2-FULL NAME Anthony Bradunas

(a) RESIDENCE. No. 42 Parkin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary A.

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Mens clothing.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Bradunas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Simkus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant John Bradunas
(Address) 42 Parkin St.

15 Filed FEB 4 - 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1924.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1922, to Feb. 2, 1924, that I last saw him alive on Feb. 1, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness M. D.

, 19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislowas	Feb. 5 - 1924

20 UNDERTAKER	ADDRESS
John Grabliauckas	425 S. Paca St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D 83405

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Reilly

(a) Residence No. Preston & Caroline Sts. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. — mos. — ds. How long in U. S., if of foreign birth? 84 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If ~~married~~ widowed, or ~~divorced~~ ~~HUSBAND of (or) WIFE of~~ Patrick Reilly

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 96 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Little Sisters of the Poor

(Address) Preston & Caroline Sts.

Filed FEB 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3 1924

17- I HEREBY CERTIFY, That I attended deceased from No record 19.. to 19..

that I last saw h... alive on July 27 19 24

and that death occurred, on the date stated above, at 3.15 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July 3 1924 (Signed) P. O'Connor, M. D

(Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. New Cathedral Cemetery Feb. 5 19 24

20-UNDERTAKER. Henry Hoerth Son ADDRESS 1201 E Eager St

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83406

CERTIFICATE OF DEATH.

100 D 83406

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 E Monument ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E. Morgan

(a) RESIDENCE NO. 1400 E Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sing'l.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 27 1922

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
	1	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Charles H. Morgan

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Anna L. Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Chas. H. Morgan

(Address) 1400 E Monument St

15 FEB 4 - 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924 to Feby 3, 1924

that I last saw him alive on Feby 2, 1924

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Bowman, M. D.

2/4/1924 (Address) 733 Augusta St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Feb. 4 1924

20 UNDERTAKER Henry Hoerdt Son — ADDRESS 1201 E Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83407

91-002 D 83407

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 N. Eden ST., 5 WARD)

2-FULL NAME Julia M. Barrett

(a) RESIDENCE NO. 317 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 Years yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 80.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Gilbert Goulter. (Address) 815 N. Chapel St.

15 Filed FEB 4 - 1924 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1924

17

I HEREBY CERTIFY, That I attended deceased from June, 1923, to Feb. 2, 1924, that I last saw h[illegible] alive on Jan 31, 1924, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

General Arterio-sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm. J. Peters, M. D.

Feb 2 1924 (Address) 701 N. Howard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Feby 5 1924

20 UNDERTAKER Henry Ward Son ADDRESS 134 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 PLACE OF DEATH 83408 ~~83408~~ X 101 001 D 83408

CITY OF BALTIMORE: (No. Volunteer Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Ziegler

(a) RESIDENCE. No. Bayside Ir. Howard ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Ziegler

6 DATE OF BIRTH (month, day, and year): Dec 7 1839

7 AGE: Years 84 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark.

PARENTS

10 NAME OF FATHER: Farber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Eagers
(Address) 21 Broad

15 FILED: ROBERT R. KRAUTER Registrar
Burial Permit Cl... FEB 4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1924, to Feb. 1, 1924, that I last saw her alive on Feb. 1, 1924, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At her home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. R. Johnson M. D.

, 19 (Address) 1210 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb 5/24

20 UNDERTAKER: Geo Rossell — ADDRESS: 1442 N Gay

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 33409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922. 69 1853.

74-001

D 33409

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1303 Presstman St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H Dennis

(Residence in Baltimore: No. 1303 Presstman St

69. St.: yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July, 1853.
(Month) (Day) (Year)

7-AGE, 69 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joshua Dennis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Julia A Williams

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Dennis

(Address) 1303 Freshman St

15-
FEB 4 - 1924 ROBERT B. KRAUTER
Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 30, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) T. Hennessy M. D.
(Coroner.)

Feb 1, 1924 (Address) 702 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Feb 3rd, 1924

20-UNDERTAKER Emmert & Wright

ADDRESS 1364 N Caroline St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83410

Registered No. C .....

1-PLACE OF DEATH

City of Baltimore (No.) 1428 Prestman St. St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Dougherty

(Residence in Baltimore: No. 1428 Prestman St. St.: 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	Widow

6-DATE OF BIRTH, about (Month) (Day) 1868 (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. Wm. H. Lee

(Address) 157 N. Calhoun St.

FEB 4 - 1924

Filed ..... 191.... ROBERT R. KRAUTER

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 1, (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

arterio sclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Feb. 2. 1924 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Feb 4th 1924

20-UNDERTAKER Barnes & Crapster — ADDRESS 1364 Park

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83411

CERTIFICATE OF DEATH.

90 D 83411

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1631 Jackson ST., 24 WARD)

2-FULL NAME Mildred S.Cairns

(a) RESIDENCE NO. 1631 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. 20 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	12	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Harry K.Cairns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Lillian M.Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Harry K.Cairns
(Address) 1631 Jackson St.

15 Filed FEB 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to Feb 1, 1924.

that I last saw h alive on Feb 1, 1924

and that death occurred, on the date stated above, at 5 P.M. a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of Heart
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R.L. Campbell M. D.

2-2 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Feb 4 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 N. Poppleton ST., 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Corrigan

(a) RESIDENCE NO. 117 N. Poppleton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Peter Corrigan,

6 DATE OF BIRTH (month, day, and year) July 10th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work, odd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Owen Corrigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland,

12 MAIDEN NAME OF MOTHER Bridget Taylor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland,

14 Informant Helen M Corrigan

(Address) 117 N Poppleton St.

15 Filed FEB 4 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1923 to Feb 3 1924.

that I last saw her alive on " " 1924

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ..... yrs. ..... mos. 5 ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Clinical

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Costello, M. D.

2/4/1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cath. Cem.	Feby 6th 1924
20 UNDERTAKER	ADDRESS
John T. Cowan & Son.	908 Eutaw
per J. T. Cowan.	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83413

CERTIFICATE OF DEATH.

3| D 83413

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1038 W Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. F. Nathalie Luebbeuser

(a) Residence No. 1038 W Fayette St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 23-1887

7-AGE, 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. housework

(b) General nature of industry, business, or establishment in which employed (or employer). home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Frank J Luebbeuser

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Susanna Cooper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Susanna Luebbeuser

(Address) 1038 W Fayette St

FEB 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Febry 3-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1923 to Febry 3 1924

that I last saw h[illegible] alive on Febry 2 1924,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pleurisy Tuberculosis.

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Holbert Keech, M. D.

, 19 (Address) 305 N Gulhowm St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer Cem.	Febry 7 1924
20-UNDERTAKER	ADDRESS
Gotlieb & Coyne & Lee & Lf Cowan.	901 Hollins St

SHOULD BE CAREFULLY EXAMINED AS TO ITS CORRECTNESS BEFORE SIGNATURE. AGE, NAMES OF PARENTS, PLACE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83414

CERTIFICATE OF DEATH.

161-002 D 83414

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 186 N. Broadway ST., 15 WARD)

2-FULL NAME Baby girl Gork

(a) RESIDENCE NO. 623 N. Pulaski ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	-	-	/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Philip Gork

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Florence —

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Church Home & Infirmary
(Address) Balto Md

15 FEB 4 - 1924 ROBERT R. KRAUTER, Registrar Female Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1924, to Feb 4th, 1924.

that I last saw her alive on Feb 4th, 1924,

and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

1 Birth trauma.
Hemorrhage Cerebral

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Difficult forceps delivery

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of Feb 4th 1924

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Autho. &

(Signed) Gaydage Pancoast, M. D.

2/4, 1924 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Henrietta Rest — DATE OF BURIAL 2/4 1924

20 UNDERTAKER Ad Levinson & Bro — ADDRESS 1127 E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 83415

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2227 E. Fayette St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Handwerger

(a) Residence No. 2227 E. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. — How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude

6-DATE OF BIRTH (month, day and year)

7-AGE. 48 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baker

(b) General nature of Industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Abraham Handwerger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Louis Weisman

(Address) 2114 E. Fayette St

Filed FEB 4 - 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 30 1924 to Feb 4 1924

that I last saw h.. alive on Feb 3 1924

and that death occurred, on the date stated above, at 4 15 a m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

Cardiac decompensation

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pancreatic stone ? Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) A J Rice, M. D.

Feb 4th, 1924 (Address) 20 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Adath Rosedale	Feb 4 1924
20-UNDERTAKER,	ADDRESS
Sol Levin & Bro	Balto St

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should be very careful to have CAUSE OF DEATH correctly specified. Exact statement of OCCUPATION is very important. See In plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83416

CERTIFICATE OF DEATH.

91-002 D 83416

D 83416
1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 300 Woodlawn Road, Roland Park Ward) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Virginia Sanner

(a) Residence No. 300 Woodlawn Road, Roland Park St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Sanner

6-DATE OF BIRTH (month, day and year) Apr, 15, 1849

7-AGE.	If LESS than 1 day,
74 yrs. 10 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, William Graham

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Sarah Ann Bean

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Harry C. Sanner
(Address) 300 Woodlawn Road

15- FEB 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Febry 2 '24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 17 1923 to Febry 2 1924
that I last saw h[er] alive on Febry 2 1924,
and that death occurred, on the date stated above, at 11.20 P. m.
The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) — yrs. — mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Wm. C. Rayner M. D.

2 Feb, 1924 (Address) 806 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cemetery	2/5, 1924

20-UNDERTAKER,	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 83417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 Light St. ST., 23 WARD)

REGISTERED NO. D 83417

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kagle.

(a) RESIDENCE No 1800 Light St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced HUSBAND of (~~WIFE~~) of Eva M. Kagle.

6 DATE OF BIRTH (month, day, and year) February 10, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery man.
(b) General nature of industry, business, or establishment in which employed (or employer) 034
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster, Md.

PARENTS

10 NAME OF FATHER George Kagle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Eichhorn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Eva M. Kagle. (wife)
(Address) 1800 Light St.

15 Filed FEB 4 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Feb. 3, 192 4 (Address) 1517 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 2 4 192 24

20 UNDERTAKER P J Fahey Sons ADDRESS 1518 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83418

CERTIFICATE OF DEATH.

44 D 83418

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N Gorsuch ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip Guglielmo

(Residence in Baltimore: No. 212 N Gorsuch St.; 28 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 5th, 1857
(Month) (Day) (Year)

7-AGE, 66 yrs. 6 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fruit Vendor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country). Italy Sicily

PARENTS.

10-NAME OF FATHER, Antonio Guglielmo

11-BIRTHPLACE OF FATHER (State or Country), Sicily Italy

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Guglielmo

(Address) 212 N Greene St.

15- FEB 4 - 1924 ROBERT R. PRENTISS

Filed....., 191..... Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2d, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 31 1924, to Feb 2nd 1924, that I saw h m alive on Feb 1st 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:-

Cancer of Stomach

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma - Hemorrhage

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Joseph L. Johnson M. D.

Feb 3, 1924 (Address) 1101 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, Feb 5, 1924

20-UNDERTAKER W. M. Rowton — ADDRESS 2238 N Howard

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83419
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001 ✓ D 83419
Registered No.....

City of BALTIMORE: (No. 3029 W North Av St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Anne Zentz

(a) Residence No. 3029 W North St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Zentz

6-DATE OF BIRTH (month, day and year) Sept 27 1853

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). At Home
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.
10-NAME OF FATHER. Wm Keiser
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.
12-MAIDEN NAME OF MOTHER. Zumbrown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Aaron D. Zentz
(Address) 3029 W North St

15-
Filed ..... 192.
FEB 4 - 1924 ROBERT R. KRAMER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). January 31 24

17- I HEREBY CERTIFY, That I attended deceased from June 14th 24 to Jan 30th 24
that I last saw h alive on Jan 31st 24
and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carbon Dioxide Poisoning Paralysis respiration (Duration) yrs.

If-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) C Emmet Jones M. D.
, 19 (Address) 2802 Roslyn Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. Feb 4, 19 24

20-UNDERTAKER. W M Routson — ADDRESS 2238 W North

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

83420 ✓

181-006 D 83420

83420

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No.) St. Joseph Hospital ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Lilly

(a) RESIDENCE NO 1904 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Lilly

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Lilly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Wigert

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant George W. Lilly
(Address) 2301 Gordon Ave

FEB 4 - 1924 ROBERT M. KRAUTER, Burial Permit Clerk.

FEB 4 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixation

Probably accidental.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Alocholism (duration) yrs. mos. ds.

(Signed) J. S. H. Wales, M. D.
(Coroner.)

2/2/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk.

DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Richard F. Cuskey

ADDRESS 1108 Guilford

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83421

CERTIFICATE OF DEATH.

74-901 ✓ D 83421

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 16 WARD)

2-FULL NAME Wm. E. Bright

(a) RESIDENCE NO. 1122 N. Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lelia Bright

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1863.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60 yrs.	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Bright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza A. Ridgway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lelia Bright
(Address) 1122 N. Carrollton Ave

15 FEB 4 - 1924 Filed ..... 192 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Feb 4, 1924 (Address) 28 Redwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dunn Loring DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Chas. H. Elsey Sons ADDRESS 400 Mosher

AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Emma Butts

D 83422 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83422

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1630 McCulloh ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Butts

(a) RESIDENCE NO. 1630 McCulloh ST., WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE: Years 42; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER George Hawley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Markham

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Stella Crumpler

(Address) 1630 McCulloh

15 FEB 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1924 to Feb 1 1924

that I last saw her alive on Jan 31 1924

and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

2-2 1924 (Address) 1939 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int-Aurlum Cemetery

DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Maryland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

La Grippe
Pulmonary Tuberculosis
Dec 11/23

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83423

101-001 D 83423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 29 Maryland Ave St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Adelaide Church

(a) Residence No. 29 Maryland Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, Husband of (or) WIFE of Stephen Church

6-DATE OF BIRTH (month, day and year) Oct 25-1848

7-AGE, 75 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Robert Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Jane A Burns

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-(Informant) Alma Church

(Address) 29 Md Ave Mt Pleasant

Filed FEB 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 2/24 at 1.40 p m.

17- I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Feb 2, 1924, that I last saw her alive on Feb 2, 1924, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) no yrs. no mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Raymond Adams, M. D.

Feb 3, 1924 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL, Feb 5, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83424 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D 83424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 Ramsey ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret V. Schwemmer.

(a) RESIDENCE No. 1329 Ramsey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Dec 6. 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Howard Schwemmer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Marie Franz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Howard Schwemmer. (Address) 1329 Ramsey St.

15 ROBERT R. KRAUTER FEB 4 - 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1924, to Feb. 2, 1924.

that I last saw h— alive on Feb. 2, 1924.

and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia, (Primary.)

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) Chas. Conkon, M. D.

2/4/24 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb 6 1924

20 UNDERTAKER John J. Fields

ADDRESS 1200 W. Lombard

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83425

CERTIFICATE OF DEATH.

31 D 83425

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N. Broadway ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry H. Mervis

(a) RESIDENCE NO. 114 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) January 21898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tinner 263
(b) General nature of industry, business, or establishment in which employed (or employer) Roofing
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Morris Mervis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Celia Meyerowitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Mrs. J. Mervis
(Address) 1141 N. Broadway

15 Filed FEB 4 - 1924 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

(Signed) J. H. Walker, M. D.
(Coroner.)

Feb 4 1924 (Address) 1086 Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wehrem Rosedale — DATE OF BURIAL 2/4 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21- E.B.R.S.-400 Bks.

D 83426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 83426

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Bolden

(a) Residence No. 963 Franklin Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 17 1859

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md
(State or Country)

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14- (Informant) Elizabeth Loughford

(Address) 3836 Falls Road

FEB 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 29 1924 to February 3 1924

that I last saw him alive on February 3 1924

and that death occurred, on the date stated above, at 8-55 A. m.

The CAUSE OF DEATH* was as follows:

Tetanus

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Frost bite gangrene left foot (Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Holy Cross	Feb 5, 1924
20-UNDERTAKER	ADDRESS
CHENOWETH & SON,	3617 CHESTNUT AVE.

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~B 90857~~ ~~83427~~ 100-001 D 83427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.**

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Ingrapt Girl Baker

(a) RESIDENCE No. 2809 Bernard St. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gladys Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 FEB 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1924, to Feb 3, 1924, that I last saw her alive on Feb 3, 1924, and that death occurred, on the date stated above, at 4½ P. m.

The CAUSE OF DEATH* was as follows:

Hare Lip - Cleft Palate

(duration) Since Birth yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of Jan. 25, 1924

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Chas. R. Bugg, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden

DATE OF BURIAL Feb 5 1924

20 UNDERTAKER CHENOWETH & SON,

ADDRESS 3617 CHESTNUT AVE.

Spec.—1-10-21—M&T—1500 Blks.

Mariam A. Richardson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83428

CERTIFICATE OF DEATH.

90 D 83428

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Appleton St ST., 16 WARD)

2-FULL NAME Mariam A. Richardson

(a) RESIDENCE No. 622 Appleton St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed~~, or Divorced, (write the word)
F.	W.	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Minnie Gossage

(Address) 622 Appleton St

15 Filed ..... 19 ROBERT R. KRAUTER Registrar

FEB 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 16th, 1924, to Feb 3d, 1924, that I last saw her alive on Feb 1st, 1924, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Hammond, M. D.

, 19 (Address) 1924 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 5 - 1924

20 UNDERTAKER Wortham D. Lore

ADDRESS 1923 W Lafayette Ave

NOTE—AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83429 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 D 83429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 7 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Buda

(a) RESIDENCE NO. 2524 McElderry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Michael Buda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Mary Konich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Reond F. Sydenham Hospital
(Address)

FEB 4 - 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1924, to Feb 3, 1924, that I last saw her alive on Feb 3, 1924, and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, maxillar & pharyngeal.
(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Scarlet fever (?)
(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures (+)

(Signed) Blue Sowan M. D.

2/4/1924 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Wm. C. Miller — ADDRESS 2334 Effingham St

N. B.—WRITE LEGIBLY. Typewriting preferred. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE • AT • EVERY • DEATH

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83430

CERTIFICATE OF DEATH.

162 D 83430

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 N. Walk St ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Colloran

(Residence in Baltimore: No. 1714 N. Walk St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	

6-DATE OF BIRTH, Feb (Month) 3 (Day) 1924 (Year)

7-AGE	If LESS than 1 day, ...hrs. or....min.?
....yrs....mos....ds.	1/2 hour

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Joseph Colloran

11-BIRTHPLACE OF FATHER (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER Gertrude Leimbach

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm K Greaghty

(Address) 203 E Preston St

15-

Filed FEB 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 3 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 3 1924, to Feb 3 1924, that I saw him alive on Feb 3 1924, and that death occurred, on the date stated above, at 11.55 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) ....yrs. 25 Minutes mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) William R Greaghty M. D.

Feb 4, 1924. (Address) 203 E Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Feb 5, 1924

20-UNDERTAKER Elmer W. Conkelin

ADDRESS 9242 Eager

10

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

K 00 D

A K S

Spec.—1-10-21—M&T—1500 Bks.

D 83431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 83431

1-PLACE OF DEATH Hebrew Hospital 5 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hudgins

(a) RESIDENCE NO. 1874 E. Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31, 1924

7 AGE — Years ..... Months ..... Days 2 — If LESS than 1 day 8 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Hudgins

11 BIRTHPLACE OF FATHER (city or town) Balto Md, (State or country)

12 MAIDEN NAME OF MOTHER Eva Ernst.

13 BIRTHPLACE OF MOTHER (city or town) Penna (State or country)

14 Informant (Address) JOHNS HOPKINS HOSPITAL FEB 4 - 1924

15 FEB 4 - 1924 ROBERT R. KRAUTER, Registrar

Deputy Registrar, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924 to Feb 2, 1924, that I last saw him alive on Feb 1, 1924, and that death occurred, on the date stated above, at 10.00 a. m.

The CAUSE OF DEATH* was as follows:

Immaturity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Isidor D. Fry, M. D.

Feb. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, Per. Wm. E. WOODALL ADDRESS .....

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

7/8

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83432

CERTIFICATE OF DEATH.

× 112 D 83432

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Stevens

(a) RESIDENCE NO. 249 W Biddle St ST., ... WARD Balto (Colored)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Father —

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Mother Powell

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 4 - 1924 ROBERT M. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 - , 1924, to Feb 3 - , 1924, that I last saw her alive on Feb 3 - , 1924, and that death occurred, on the date stated above, at 1240 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Stomach & Duodenum

(duration) 0 yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) None over

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? 249 W. Biddle St.

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bagg, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bloomberg C. C. | DATE OF BURIAL 2-5 1924

20 UNDERTAKER George T. A. Gibson | ADDRESS 1735 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown

Spec.—1-10-21—M&T—1500 Bks.

1691113 83433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 16

REGISTERED NO. 59-003 ✓ D 83433

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucilla Nelson

(a) RESIDENCE NO. 3036 Freeman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 23/1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 4 yrs

(c) Name of employer 4

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Inez Darkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1924, to Feb 2, 1924, that I last saw her alive on Feb 2, 1924, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Meningococcal sepsis

(duration) yrs. 10 mos 21 ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 3036 Freeman St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. L. Reichert M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	2/6 1924
20 UNDERTAKER George T. A. Gibson	ADDRESS 1735 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Malformation.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83434

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-00 V D 83434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1204 Rutter St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Davis

(a) Residence No. 1204 Rutter St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Davis

6-DATE OF BIRTH (month, day and year) Oct 3 - 1871

7-AGE. 52 yrs. 4 mos. — ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) John Davis

(Address) 1204 Rutter Street

15- FEB 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 27, 1924 to Feby 3, 1924

that I last saw h[illegible] alive on Feby 2, 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Grippe

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Pettat [illegible] M. D.

, 19 (Address) 817 Hamilton Ter

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	2/5/24
20-UNDERTAKER.	ADDRESS.
George T. A. Gibson	1735 Druid Hill Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83435

D 83435

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Albion Hotel ST., 11 WARD)

2-FULL NAME Ella ~~Cutsail~~ Culbreth

(a) RESIDENCE NO. Albion Hotel, Richmond & Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 2 1840

7 AGE: Years 74 Months 6 Days 29 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Owner of Albion Hotel

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys County Maryland

PARENTS

10 NAME OF FATHER: James Culbreth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Virginia Redden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Mrs. Ella Culbreth 53 E. Eager St

15 FEB 4 - 1924 ROBERT P. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 3 1924

17

I HEREBY CERTIFY, That I attended deceased from ....., 1921, to Feb 3, 1924.

that I last saw her alive on Feb 3, 1924,

and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. Cured

18 Where was disease contracted if not at place of death?

Did an operation precede death? ~~Called~~ Date of 1918

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic changes

(Signed) Chas Cly Judd, M. D.

. 19 (Address) 170 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friends Cem

DATE OF BURIAL: 2-5 1924

20 UNDERTAKER: Henry W. Jenkins & Sons Co

ADDRESS: Guilford Avenue

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83436

CERTIFICATE OF DEATH

74-001 ✓ D 83436

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1155 Homestead St ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Bandell

(a) RESIDENCE NO 1155 Homestead St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (Late) ANN G. Bandell

6 DATE OF BIRTH (month, day, and year) Aug 17/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER C.M. Bandell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Md.

12 MAIDEN NAME OF MOTHER Ann G. Graff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14
Informant Mrs. Sadie Bandell
(Address) 1155 Homestead St.

Filed FEB 4 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility- arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Feb 2/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	2/5 1924
20 UNDERTAKER George J Ruth	ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83437

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Franklin Terrace ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick C. Meineke

(a) RESIDENCE NO. 514 Franklin Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary E Meineke

6 DATE OF BIRTH (month, day, and year) Feby 5th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly 080

(b) General nature of industry, business, or establishment in which employed (or employer) St Josephs Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Meineke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary E Meineke

(Address) 514 Franklin Terrace

15 Filed ....., 19.. Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1924, to Feb 8, 1924, that I last saw him alive on Feb 8, 1924, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

1- Erysipelas, facial

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Probably at place of employment

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Herbert Kemp, M. D.

Feb 10 (Address) 1216 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Feby 7th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

B4 - 1924 Burial Permit Clerk

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should supply information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient also had—
Chronic valvular Heart Disease
arteriosclerosis
Chronic Nephritis prostatic sclerosis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83438

CERTIFICATE OF DEATH.

99-001 D 83438

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 William ST., 24 WARD)

2-FULL NAME Catherine E. Wengert

(a) RESIDENCE NO. 1731 William ST., 24 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 8 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Wengert

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Carry Easton

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Wm Wengert (Address) 731 Kenyon Ave.

15 Robert F. [illegible] Burial Permit Clerk. Registrar

B4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 4, 1924, that I last saw h alive on Feb 4, 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. H. Campbell, M. D.

Feb 4, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville

DATE OF BURIAL 2/6 1924

UNDERTAKER A. J. Baker & Sons

ADDRESS 131 E. Eager St.

N.B.—WHITE PENCIL should not be used in filling out this certificate. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typboid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83439

CERTIFICATE OF DEATH.

3 51

D 83439

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Garzak

(a) Residence No. 151 ~~Thomas~~ Thames St., ... St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1855

7-AGE.	If LESS than 1 day.
69 yrs. ..... mos. ..... ds.	....hrs. or... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant) Municipal Hospital Record.

(Address) .....

15- Robert P. Harrison,

Filed ..... 1924 ..... 192.... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 30 19 24 to February 1 19 24

that I last saw her alive on February 1 19 24

and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus,

Chronic Myocarditis,

Myocardial degeneration,

(Duration) ..... yrs. 2 mos. (Est.)

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Claude S. Dreas, M. D

2-2- 19 24 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 19....
Holy Rosary Cem.	Feb 5
20-UNDERTAKER, Dade Funeral Home	ADDRESS 1128 E. Baltimore St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use PLAIN SINGLE terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B4

Spec.—1-10-21—M&T—1500 Bks.

D 83440

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83440

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH Colonial Hosp.

CITY OF BALTIMORE (No. 1112 N. Monut ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Duvall

(a) RESIDENCE NO. 1545 Friendship ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/16/1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer) — 031

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) John Duvall 1545 Friendship St

15 2-4-1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2/24 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1924, to Feb. 2, 1924

that I last saw him alive on Feb. 2 1924

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

approximately 1 wk

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Appendiceal abscess

Peritonitis — duration (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Feb. 1, 1924

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) A. A. Lyon M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	2/4/1924
20 UNDERTAKER Geo Leimbach & Son	ADDRESS 647 W Pratt St

AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

mation should be carefully supplied. AG CAUSE OF DEATH in plain terms, so

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83441

CERTIFICATE OF DEATH.

D 83441

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Bennett Place ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Elizabeth Green

(a) RESIDENCE NO. 1002 Bennett Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) WIFE of Nicholas H Green

6 DATE OF BIRTH (month, day, and year) Dec 2 1852

7 AGE: Years 71 Months 2 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Wesley Sank

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Henrietta Trombo

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Miss Lillie Green

(Address) 1002 Bennett Place

Filed FEB 4 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1923, to Feb 2, 1924, that I last saw h.. alive on Feb 2, 1924, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Myocarditis

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? 0

(Signed) J. H. Mewborn, M. D.

Feb 4. 1924 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: FEB 5 1924

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83442

CERTIFICATE OF DEATH.

74 09 D 83442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 E. Fulton Ave ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth McElroy

(a) RESIDENCE NO. 1129 E. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Wm. McElroy

6 DATE OF BIRTH (month, day, and year) Sept. 10-1840

7 AGE ~~65~~ Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
83	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Ohio

PARENTS

10 NAME OF FATHER Thos. Robinson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Kinney

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Informant Mrs. Gertrude Buck
(Address) 1129 E. Fulton Ave.

15 Robert P. Harrison,
Registrar
Burial Permit Clerk.

FEB 4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 3 - 1924, to Feb 4 - 1924,

that I last saw her alive on Feb 3 - 1924,

and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. McElroy Tarbert, M. D.

. 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore — DATE OF BURIAL FEB 7 - 1924 19

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

FILL IN ALL BLANKS. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83443

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 White Avenue St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Murphy

(a) Residence No. 32 White Avenue St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 24, 1886

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Window Dresser

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: John C. Murphy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): New York N.Y.

12-MAIDEN NAME OF MOTHER: Mary Hanretty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md

14- (Informant) John F. Murphy

(Address) 32 White Avenue

15- FEB 4 - 1924 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 1 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 19 24 to Feb 1 19 24

that I last saw h[illegible] alive on Feb 1 19 24

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Bruce, M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	2/5, 1924

20-UNDERTAKER	ADDRESS
George J. Ruth	1735 Hanford Ave

INSTRUCTIONS: Fill in all blanks. Use ink. Write plainly. Spell out all words. Do not abbreviate. Answer each question carefully. If unknown, say so. Do not leave blanks unless impossible to supply. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83444 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83444

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 416 N. Fremont St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas L. Sparks

(Residence in Baltimore: No. 416 N. Fremont St. Ltr Yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
65 yrs. 5 mos. 23 ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Printer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Chas L Sparks

11-BIRTHPLACE OF FATHER. (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. [illegible]

13-BIRTHPLACE OF MOTHER. (State or Country). [illegible]

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Sparks

(Address) 4208 Park Heights Ave.

15- Robert P. Harrison

Filed ..... 192.....

Registrar.

EB 4 - 1924 Serial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. (Month) 3 (Day) ....., 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few days (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

2-4- 192.4 (Address) 11 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount X	2/7/24 19....

20-UNDERTAKER.	ADDRESS
Fred A. Krause & Son	703 Hanover St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.G.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83445

CERTIFICATE OF DEATH.

1-001 D 83445

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hos. St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Kohler

(a) Residence No. 2544 Hilkens Ave. City St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 2-1894

7-AGE. 29 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Clerk - 009

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER Daniel H. Kohler

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mary L. Goldman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14-(Informant) Mrs Mary Kohler

(Address) 2544 Hilkens Ave

15-Filed FEB 4 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 31-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 24 1924 to Jan 31 1924

that I last saw him alive on Jan. 31 1924

and that death occurred, on the date stated above, at 6.00 P M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. Goldman M. D

19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL Feb 3rd 1924

20-UNDERTAKER. F. D. Heppenstall ADDRESS 2236 Fred'k Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 83446

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

2-FULL NAME William Otto

(a) RESIDENCE NO. 1137 Homestead Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Otto

6 DATE OF BIRTH (month, day, and year) July 1876

7 AGE — Years: 47 — Months: 7 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Oscar Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant M. Otto (Address) 1137 Homestead St

15 Filed 2-4-1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1923, to February 2, 1924.

that I last saw him alive on February 2, 1924,

and that death occurred, on the date stated above, at 3-10 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis - (Cerebro Spinal)

Hemiplegia - Right

Chronic Myocarditis - Syphilitic

(duration) 20? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ... yrs. 5 mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Faulton, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cemetery — DATE OF BURIAL: Feb 5th 1924

20 UNDERTAKER: F. B. Kefferput — ADDRESS: 2236 Eutaw Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83447

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83447

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Presbyterian Home of Maryland ST., 16 WARD)

2-FULL NAME Maria Louisa Kneller

(a) RESIDENCE No. 822 N. Carrollton ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob A. Kneller

6 DATE OF BIRTH (month, day, and year) Sept 30 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore / Md

PARENTS

10 NAME OF FATHER Daniel Hayes Candler

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Miss Mary C. Robb

(Address) Supt Presbyterian Home of Md

15 Robert F. Harrison, Registrar

B 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4. 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 31 - 1924 to Feb. 4 - 1924, that I last saw h[illegible] alive on Feb 3 - 1924, and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation & Edema of legs
" " & Renal pain

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial asthma. Dyspepsia of 4 months (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? general medical

(Signed) Charles W. Cook M. D.

Feb 7, 1924 (Address) 2219 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feby 6 1924
20 UNDERTAKER	ADDRESS
Chas. S. Black	412 W. North ave

...MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Fluid ave Fairfield St., 75 Ward) Registered No. 80

2-FULL NAME Clarence A. Carson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. Third Ave, Fairfield Md St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 29, 1924

7-AGE, ...yrs. ....mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Fairfield (State or Country), Md

PARENTS.

10-NAME OF FATHER, Abner M. Carson

11-BIRTHPLACE OF FATHER (city or town) Franklin Township (State or Country), north Carolina

12-MAIDEN NAME OF MOTHER, Mattie R. Jones

13-BIRTHPLACE OF MOTHER (city or town) Wilkesboro (State or Country), N Carolina

14- (Informant) Abner M. Carson

(Address) Fairfield, Md.

15- Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

FEB 5 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 4 1924

17- I HEREBY CERTIFY, That I attended deceased from July 31, 1924, to July 4, 1924, that I last saw he alive on July 3, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Malaria

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Leitheiser M. D.

, 19 (Address) 1340 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, W W Laurel Cem. DATE OF BURIAL, 2/5, 19..

20-UNDERTAKER, Jno H Jordan ADDRESS 142 W Fayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient; e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cause Unknown

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83449

D 83449

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1083 W Fayette St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie B. Burton

(a) Residence No. 1083 W Fayette St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wm Burton

6-DATE OF BIRTH (month, day and year): Sept 16 1844

7-AGE: 79 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Augustus W Biles

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Martha —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14- (Informant): Wm N. Spear

(Address): 2003 N Wolfe St

15- ROBERT B. KRAUTER, Burial Permit Clerk.

FEB 5 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 31 1924 to Feb 3 1924

that I last saw her alive on Feb 3 1924

and that death occurred, on the date stated above, at 1-30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) Ones 4 ds.

CONTRIBUTORY (Secondary): Myocarditis + Arterio sclerosis

(Duration) Ones 4 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry L. Dibble M. D.

Feb 4. 1924 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Feb 5 1924

20-UNDERTAKER: John C. Mitchell

ADDRESS: 1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83450

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 83450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 Florence St., 13 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shilson Mack—

(a) RESIDENCE No. 2626 Florence ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Mack—

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 51; Months; Days; If LESS than 1 day,.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Charles Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.—

12 MAIDEN NAME OF MOTHER: Georgiana Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Mack.

(Address) 2626 Florence St.

15 Filed FEB 5 - 1924, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 30th 1924 to Feb 2nd 24.

that I last saw him alive on Feb 1 1924

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH was as follows:

Lobar-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. not known ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

Feb 3, 1924 (Address) 153 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cr

DATE OF BURIAL: Feb 5 1924

20 UNDERTAKER: L. V. Brown & Son

ADDRESS 1084 W. Mont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 8345I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 8345I

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 156 Church St., 22 WARD)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. 156 Church ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	C	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Gross
(Address) 156 Church

15 FEB 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924, to Feb 2, 1924, that I last saw h alive on Feb 1, 1924, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulm Oedema
(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of No

Was there an autopsy? .....

What test confirmed diagnosis? J Howard

(Signed) J Howard, M. D.

Feb 4th 1924 (Address) 709 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 5 1924
20 UNDERTAKER	ADDRESS
J Wm Brown & Son	618 W Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83452

CERTIFICATE OF DEATH.

101 001 D 83452

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 May St. ST., 5 WARD)

2-FULL NAME Laura Morris.

(a) RESIDENCE NO. 1405 May St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer) — 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura Bostar 1405 May St.
(Address)

15 Filed FEB 5 - 1924 ROBERT S. BRAUTEN Asst. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 19 24

17

I HEREBY CERTIFY, That I attended deceased from Jan 13, 1924. to Feb 3, 1924.

that I last saw him alive on Feb 3, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Robt. J. Green, M. D.

2-4-, 1924 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL Feb. 6 1924

20 UNDERTAKER Chas. H. Johnson — ADDRESS 446 N. Caroline St.

N.B.—WHITE PENCIL MUST NOT BE USED IN FILLING OUT THIS CERTIFICATE. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 83453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 83453

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mother House of Notre Dame St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister Mary Vitaline Roman

(Residence in Baltimore: No. Lisquith St and Ashland Ave St.: 24 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, October 31, 1854
(Month) (Day) (Year)

7-AGE, 69 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Adam Roman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Hornung

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sr. M. Dionede

(Address) Notre Dame Lisquith St.

15-

Filed FEB 5 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 4, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1924, to July 4 1924, that I saw her alive on July 1 1924, and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Incurable Cancer of Breast Metastasis in Liver (Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) F. J. Kelly M. D.

(Address) 110 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Notch Cliff Md. DATE OF BURIAL, Feb. 6, 1924

20-UNDERTAKER Frank A. Fink ADDRESS 915 N Gay St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83454

CERTIFICATE OF DEATH.

154-065 83454

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hopkins Hospital ST., 17 WARD)

2-FULL NAME Baby McQuay

(a) RESIDENCE No. 1101 ½ Myrtle Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Thomas McGuay

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Dickson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant ..... (Address) Johns Hopkins Hospital

FEB 5 - 1924 ROGER L. KRAUTER, Registrar

Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Jan 30, 1924.

that I last saw him alive on Jan 30, 1924,

and that death occurred, on the date stated above, at 6.00 a m.

The CAUSE OF DEATH* was as follows:

Meningitis ? Cerebro Spinal

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Spina bifida congenital.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Kleinschmidt M. D.

1/30 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ADDRESS: FEB 4 - 1924

20 UNDERTAKER: Commissioner Health,

N. B. WRITE PLAINLY WITH UNFADING INK. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83455

CERTIFICATE OF DEATH.

31

D 83455

1-PLACE OF DEATH

CITY OF BALTIMORE. (No 3418 Garrison Ave ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar C. Harvey

(a) RESIDENCE. No. 3418 Garrison Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 25 - 1888

7 AGE: Years 35 Months 8 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Selling Stocks & Bonds

(c) Name of employer: Stone

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Howard Linton Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bruce Geo Co

12 MAIDEN NAME OF MOTHER: Elizabeth A. Ryon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Prince George Co

14 Informant: Father. Howard Linton Harvey

(Address) 3418 Garrison Ave

15 .....

FEB 5 - 1924 ROBERT R. KRAUTER. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 1923 to Feb 3 1924, that I last saw him alive on Feb 2 1924, and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) Over 7 mos. ds.

CONTRIBUTORY (Secondary): None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D.

Feb 4 1924 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Feb 6 1924

20 UNDERTAKER: George J. Smith — ADDRESS: 532 Hollins

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10 21 M&T 1500 lks.

Marie L. Pattison

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
100 D 83456

CERTIFICATE OF DEATH.

D 83456

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Liberty Heights Ave., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie Bauer Pattison

(a) RESIDENCE NO. 3508 Liberty Heights Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of M. J. Pattison

6 DATE OF BIRTH (month, day, and year) Oct 6 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Penna

PARENTS

10 NAME OF FATHER Geo. D Chamberlain

11 BIRTHPLACE OF FATHER (city or town) Phila
(State or country) Penn

12 MAIDEN NAME OF MOTHER Maria Chamberlain

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country)

14 Informant M. O. Freir
(Address) 3508 Liberty Heights

FEB 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to Feb. 3, 1924, that I last saw h.. alive on " 2, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Colston, M. D.

2/4, 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Feb 6th 1924

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh Eutaw & Fr

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83457

D 83457

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. 508 McMechen ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Rebecca Stewart

(a) RESIDENCE. NO. 508 McMechen ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Daniel E. Stewart

6 DATE OF BIRTH (month, day, and year) Sept 8. 1868

7 AGE: Years 55; Months 4; Days 24; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Catonsville Md.

PARENTS

10 NAME OF FATHER: Solomon Rosier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Catonsville Md.

12 MAIDEN NAME OF MOTHER: Frances Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Catonsville Md.

Informant: Anna Rosier

(Address) 1211 Pennsylvania Ave

Filed FEB 5 - 1924 19.. ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18 1923 to Feb 2 1924, that I last saw h[illegible] alive on Feb. 2 1924, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wilson R. Wright, M. D.

(Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2/5 1924

UNDERTAKER: Samuel Heusby

ADDRESS 578 Edd

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 83458

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 735 W. Mulberry ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Jackson

(a) RESIDENCE NO. 735 W. Mulberry. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Jackson

6 DATE OF BIRTH (month, day, and year) January 13-1892

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	32	—	19 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair-Dresser. Ob

(b) General nature of Industry, business, or establishment in which employed (or employer) Hair-Dresser.

(c) Name of employer Do business for herself.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Loyd Fortie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Cecelia Quiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Cecelia Matthews (Address) 735 W. Mulberry St

FEB 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1 1924

17

I HEREBY CERTIFY, That I attended deceased from February 2, 1922, to February 2, 1924, that I last saw her alive on February 1, 1924, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary examination

(Signed) Chester Riland, M. D.

2-2-1924 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
Pet Cemetery Co	2-5-24
UNDERTAKER Samuel Newsley	ADDRESS 1 Biddle

NOTE—PLEASE, WITH CONFIDENCE, FURNISH ALL INFORMATION REQUIRED. EACH ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—1-10-21 – M&T – 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83459 — 12 — 398

CERTIFICATE OF DEATH.

129 D 83459

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Coates

(a) RESIDENCE NO. 636 Josephine St., 4th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Coates

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
51	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ins Agt.

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 FEB 5 - 1924 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to Jan 31, 1924, that I last saw him alive on Jan 31, 1924, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Chronic Nephritis

(duration) 3. yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis - Uraemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) T. R. Hannon, M. D.

2/1/24 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Loudenslager Cem.	2/6 19 24
UNDERTAKER Samuel Hensley	ADDRESS 1 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D83459 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., ... WARD)

2-FULL NAME Raymond Coates

(a) RESIDENCE No 636 Josephine St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mary Francis Coates

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance
(b) General nature of industry, business, or establishment in which employed (or employer) Solicitor
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bal to. Md

PARENTS

10 NAME OF FATHER Jesse Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co . Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary F. Coates
(Address) 636 Josephine St

15 Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic & Myocardial Insufficiency

(Autopsy at Hopkins)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia-renal insuff.
due urethral stricture ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hall, M. D.
(Coroner.)

Feb 3/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Krokowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 83460

101 D 83460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Krokowska

(a) RESIDENCE NO. 716 South Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Krokowski

6 DATE OF BIRTH (month, day, and year) Oct 10 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mr Walter Krokowski 716 S Broadway

15 FEB 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1924, to Feb 4, 1924, that I last saw her alive on 5-A.M. - Feb 4, 1924, and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidor S. Fry, M. D.

Feb. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 6 1924

20 UNDERTAKER ADDRESS

John H Weber 1803 Bank

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83461

CERTIFICATE OF DEATH.

31 D 83461

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1920 W. Mulberry St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Robert Grimes

(a) Residence No. 1920 W. Mulberry St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 2, 1875

7-AGE. 48 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Fairfield Dairy Co.

(c) Name of employer

9-BIRTHPLACE (city or town) Woodsboro (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Ephraim D. Grimes

11-BIRTHPLACE OF FATHER (city or town) Woodsboro (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Anna Harmis

13-BIRTHPLACE OF MOTHER (city or town) Woodsboro (State or Country). Maryland

14- (Informant) Clara G. Turfle

(Address) 1920 W. Mulberry St.

15- FEB 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 20 1924 to February 3d 1924

that I last saw him alive on February 3d 1924

and that death occurred, on the date stated above, at 9.45 Am.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum

(Signed) John Vanaeli M. D.

2-4, 1924 (Address) 525 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodsboro Md.	Feb 6, 1924
20-UNDERTAKER.	ADDRESS
Jos. Block	1003 W. Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83462

CERTIFICATE OF DEATH.

'43

D 83462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Tew Hills ST., 28 WARD)

2-FULL NAME Thomas A Crowley

(a) RESIDENCE NO. Tew Hills ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Patrick Crowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Gaffney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William J. Crowley (Address) 2115 N. Pulaski Street

15 FEB 5 - 1924 ROBERT N. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1922, to Feb. 4, 1924, that I last saw h... alive on Feb 4, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Jaw

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

2-5, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Feb 6 1924

20 UNDERTAKER Jos B Cook — ADDRESS 1003 Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83463

CERTIFICATE OF DEATH.

+ 90 D 83463

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 3012 O'Donnell St., St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Adriana E. Stiff

(a) Residence No. 3012 O'Donnell St. St., Ward. Tujunga

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Stiff

6-DATE OF BIRTH (month, day and year) April 11-1861

7-AGE. 62 yrs. 9 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Middlesex Co. (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, George Bull

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Mary A. Miles

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Virginia

14- (Informant) Louisa A. Adams

(Address) 3012 O'Donnell St.

15- FEB 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 17 1924 to Feb 3 1924

that I last saw h. alive on " 3 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Acute mos. 17 ds.

CONTRIBUTORY (Secondary) Val. Dis. Heart

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Neer M. D

2/4/24 (Address) 408 S. Patterson Pk Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hardens Virginia

DATE OF BURIAL. Feb. 5, 1924

20-UNDERTAKER. H. Sander & Sons

ADDRESS 1710 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83464

CERTIFICATE OF DEATH.

90 D 83464

Registered No.....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 2101 E. Baltimore St., 3 Ward)

2-FULL NAME Samuel Goldberg

(a) Residence No. 1011 Granby Street St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Morris Goldberg

(Address) 1805 Dresbury St

15- FEB 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 4. 24

17- I HEREBY CERTIFY, That I attended deceased from April, 19 24 to Feb 4, 19 24

that I last saw h.. alive on Feb 4, 19 24

and that death occurred, on the date stated above, at 7.35 a m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

arterio sclerosis

(Duration) 6 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Peterson M. D.

Feb 5, 1924 (Address) 1810 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Rosedale — DATE OF BURIAL, Feb. 5 19 24

20-UNDERTAKER, Jack Levin — ADDRESS 1499 E. Biddle

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83465 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83465

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 N. Monroe ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hershow known as Jacob Cohen

(a) RESIDENCE. No. 1608 N. Appleton ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessis —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Levin

(Address) 1439 E. Baltimore

FEB 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to Feb 4, 1924, that I last saw h[illegible] alive on Feb 4, 1924, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs & kidneys

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I Frederick Lenz, M. D.

2-5, 1924 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Feb 5 1924
20 UNDERTAKER	ADDRESS
Fast Levin	1439 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Douglas
Doc Beckwith

D 33466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83466

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 844 W. North ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Rodenhiser

(a) Residence No. 844 W. North ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George W. Rodenhiser

6-DATE OF BIRTH (month, day and year) March 9, 1854

7-AGE. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Delaware

PARENTS.

10-NAME OF FATHER, Alex Clemans

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Delaware

12-MAIDEN NAME OF MOTHER, W. N. Weldon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Delaware

14- (Informant) George W. Rodenhiser

(Address) 844 W. North ave

15- FEB 5 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 24th 19.24 to Feby 4th 19.24

that I last saw h-- alive on Feby 4th 19.24

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Oedema of the Lungs

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 2 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Eug. A. Douglas, M. D

Feby 5 1924 (Address) 830 W. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Still Pond Chesterlong Md DATE OF BURIAL. Feb 6, 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 East North ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83467 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 83467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Krause

(a) Residence No. Pay View Asylum St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Apr 7 1861

7-AGE. 62 yrs. 9 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Krause

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Records.

(Address)

15- FEB 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 2 1924 to February 4 1924 that I last saw h. im alive on February 3 1924, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Chronic Infectious Arthritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) Claude S. Drew M. D

2-4- 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore	Feb 5, 1924
20-UNDERTAKER.	**ADDRESS**
Wm Cook	502 E Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83468

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Emersonian Apts. 3 A. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Strouse.

(a) Residence No. Emersonian Apts. 3 A. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Strouse

6-DATE OF BIRTH (month, day and year): May 22, 1844.

7-AGE: 79 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Ferdinand Strauss

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Rebecca Hess.

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Germany.

14-

(Informant) Mr. F. Strouse

(Address) Emersonian Apts.

15-

FEB 5 - 1924

ROBERT A. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 2/4/24.

17- I HEREBY CERTIFY, That I attended deceased from ..... 19 10 to Feb 4 19 24

that I last saw h Hr alive on Feb 4 19 24

and that death occurred, on the date stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(Duration) — yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Laboratory tests

(Signed) Harry Adler M. D

2/4/ 1924 (Address) 1778 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cem. DATE OF BURIAL: 2/6/24 19....

20-UNDERTAKER: David Sondheim ADDRESS 115-20 W. Mt. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 83469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 B 001 ✓ 83469

1-PLACE OF DEATH

City of BALTIMORE: (No. 2324 Eager Place St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Helen Orner

(a) Residence No. 2324 Eager Place St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Infant

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) June 2/24

7-AGE. If LESS than 1 day,

..... yrs. 1 mos. 2 ds. .... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country).

PARENTS.

10-NAME OF FATHER, Charles Orner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER, Sophie Gould

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-

(Informant) Charles Orner

(Address) 2324 Eager Place

15-

FEB 5 - 1924

16-

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) February 4/24

17- I HEREBY CERTIFY, That I attended deceased from January 1924 to February 3 1924

that I last saw h.. alive on February 3 1924

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D

Feb 4, 1924 (Address) 2005 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Feb 6, 1924

20-UNDERTAKER.	ADDRESS
Frank Brackson	1906 Oakland Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83470 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83470

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1909 Mc Elderry St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cenna Frynchaor

(a) Residence No. 1909 Mc. Elderry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Carter

6-DATE OF BIRTH (month, day and year) July 4 1858

7-AGE. 65 yrs. 10 mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ceerstria

PARENTS.
10-NAME OF FATHER, Joseph Petrick
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria
12-MAIDEN NAME OF MOTHER, Mc Brown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant) Clara Bullock
(Address) 1909 Mc Elderry St

15-FILED FEB 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 4 1924

17- I HEREBY CERTIFY, That I attended deceased from February 3 1924 to February 4 1924

that I last saw h.. alive on February 4 1924

and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D

Feb 4. 1924 (Address) 2025 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer | DATE OF BURIAL Feb 7, 1924

20-UNDERTAKER, Ernest Crocheron | ADDRESS 1906 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 83471

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenway Apts ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Rob Slagle

(a) RESIDENCE NO. Greenway Apts ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. 5 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob W. Slagle

6 DATE OF BIRTH (month, day, and year): Aug 19 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Wrightsville Penna

PARENTS

10 NAME OF FATHER: David Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wrightsville Penna

12 MAIDEN NAME OF MOTHER: Carrie Levergood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wrightsville Penna

14 Informant: Jacob W. Slagle (husband)

(Address) Greenway Apts

15 FEB 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Feb 3, 1924, that I last saw h[illegible] alive on Feb 3, 1924, and that death occurred, on the date stated above, at 930a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Clinical

(Signed) [illegible], M. D.

74, 1924 (Address) 1013 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Feb 5/1924

20 UNDERTAKER: STUART & MOWEN COMPANY (William F. Wooden, Successor) — ADDRESS: 108 W. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate. ANS should sta. t statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar Edenwald
1013 N Charles St

Cor.—1-12-23—M&T—100 Bks.

D 83472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83472

CERTIFICATE OF DEATH. 199

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Cedar St. Westport. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M. Musgrove.

(a) RESIDENCE NO 207 Cedar St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 4 mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 30th. 1904.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	4	3.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Car washer
(b) General nature of industry, business, or establishment in which employed (or employer): U.R.R. O
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas. W. Musgrove.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Louisa Zuhrian.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Chas. W. Musgrove. (father).
(Address): 1108 Ward Street.

15 Filed 2/5/24 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 3rd, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest & autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infection of the Uterus, due to an incomplete abortion. Homicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Leonhardt, M. D. (Coroner.)

Feb. 8th, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: 2/7 1924

20 UNDERTAKER: Jos. J. Gable ADDRESS: 1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

83472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D 83472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Cedar Ln ST., 7-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine M Musgrave.

(a) RESIDENCE NO. 207 Cedar ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14y yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 31-1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lace washer

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer " "

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas H Musgrave

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louise Zuhlsdorf

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Chas H Musgrave
(Address) 108 West St

Filed FEB 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3- 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-28-, 1924, to 2-3-, 1924, that I last saw h.. alive on 2-3-24, 19..., and that death occurred, on the date stated above, at 20 m..

The CAUSE OF DEATH* was as follows:

a Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Grip

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Brown, M. D.

, 19 (Address) 1117 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feb 6 1924

20 UNDERTAKER John J Fields — ADDRESS 1210 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

169 D 83473 ✓ D 83473

40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 17 WARD)

2-FULL NAME Sallie Wilson

(a) RESIDENCE No. 1616 Latrobe St WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer H

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Martin Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Lucindia Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolena. ?

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed FEB 5 - 1924 ROBERT R. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1924, to Feb 4, 1924, that I last saw her alive on Feb 4, 1924, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Myomata uteri.
Pyosalpinx, bilateral.
Abdominal abscess.
(duration) about 2 mos ds.

CONTRIBUTORY (Secondary) Secondary anemia.
(duration) about 2 mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings.

(Signed) R. W. Te Linde, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 4 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.;, Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus Infection

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83474

CERTIFICATE OF DEATH.

100-001 ✓ D 83474

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 709 N. Caroline ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Judy Francis Reeves

(a) RESIDENCE NO. 709 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
✓	1	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...Inf. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edgar Reeves

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary T. Flurer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Mary T. Reeves
(Address) 709 N. Caroline St.

15 FEB 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 Feb 1924

17 I HEREBY CERTIFY, That I attended deceased from 2 Feb, 1924, to 3 Feb. 1924.

that I last saw her alive on " " 1924

and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH was as follows:

Bronchio-Pneumonia.

General

(duration) yrs. 1 mos ^ ds.

CONTRIBUTORY (Secondary) Empyema

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Whitefield Boyle M. D.

1924 (Address) 4 W. N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery

DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83475

CERTIFICATE OF DEATH.

162 D 83475

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Edmondson Av ST.: 16 WARD)

2-FULL NAME Ruby Stack

(a) RESIDENCE. No. 906 Edmondson Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed (write the word)
Female	White	—

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 5 - 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edgar P. Stack

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Edgar P. Stack
(Address) 906 Edmondson Ave

15 Filed ..... 19 ..... Registrar

FEB 5 - 1924 Robert P. Harrison

Daniel Durett Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1924, to Feb 5, 1924, that I last saw her alive on Feb 5, 1924, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Delayed Labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Feb 6, 1924 (Address) 885 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	2/5 1924

20 UNDERTAKER James Duginan & Son ADDRESS 1806 E Pacca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83476

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 83476

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2918 Clifton Park Terrace WARD)

REGISTERED No. C .....

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes E. Walter

(Residence in Baltimore: No. 2918 Clifton Park Ter. St.: ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Dec 25, 1900 (Month) (Day) (Year)

7-AGE: 23 yrs. 1 mos. 8 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Jacob G. Walter

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Anna V. Pohl

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Edna Walter

(Address) 2918 Clifton Pk Ter

15

Filed FEB 5 1924, 191

Robert F. Harrison, REGISTRAR

Burial Permit 61[illegible]

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb. 2, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1923 to Feb. 1, 1924, that I saw h[illegible] alive on Feb 1, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chron

... (Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) ...

... (Duration) ... mos. ... ds.

(Signed) Franklin S. Tolley M. D.

Feb 3, 1924 (Address) 1813 Eutaw Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 2/6, 191[illegible]

20-UNDERTAKER: Forrest Finley ADDRESS: Fulton & Ley

Spec.—8-24-14—M. & T.—2000 Bks.

D 83477 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83477

CERTIFICATE OF DEATH.

REGISTERED NO. C 34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen F. Jackson

(Residence in Baltimore: No. 1335 Argyle Av St.; 34 yrs. 4 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Sept. (Month) 19 (Day), 1889 (Year)

7-AGE, 34 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Public School

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William D. Jackson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret H. Henry

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret H. Jackson

(Address) 1335 Argyle Ave

15- FEB 5 1924 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1923, to Feb 2 1924, that I saw h er alive on Feb 2 1924, and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia Abscess

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 2 mos. 14 ds.

(Signed) H. E. Hughes M. D.

Feb 3, 1924 (Address) 1413 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 14 ds. In the State 34 yrs. 4 mos. 14 ds.

Where was disease contracted, if not at place of death? 1335 Argyle Av

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	Feb. 6, 1924

20-UNDERTAKER	ADDRESS
Jno. M. Johnson	1309 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83478

CERTIFICATE OF DEATH.

100-69 D 83478

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

2-FULL NAME Penjamin C. Harden

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records

(Address)

15 Filed FEB 5 - 1924, 19 Robert F. Harrison Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1924

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1924, to February 2, 1924, that I last saw h im alive on February 2, 1924, and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY Bronchopneumonia

(Secondary) (Terminal) (duration) ... yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Dreyer, M. D.

2-4-1924 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL ... 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Dept. of Laboratory Health

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83479

D 83479

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., Municipal Tuberculosis Hospital WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jackson

(a) RESIDENCE No. 783 Sarah Ann st. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Devonshire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Records JOHNS HOPKINS HOSPITAL

(Address) M.T.H.

15 Filed Feb 4 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1923, to Feb. 3, 1924,

that I last saw her alive on Feb. 3, 1924,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) La Lelly, M. D.

2-4-24, 19 (Address) Municipal Tb. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS

Pat. Tim. S. [illegible]

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Any information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 83480

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinkscales. Cora

(a) RESIDENCE NO. 127 Bleckley ST., WARD Anderson — S. C

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Mr. P.E. Clinkscales

6 DATE OF BIRTH (month, day, and year) April 15 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) South Carolina
(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) —

14 Informant Friends. Johns Hopkins Hospital.
(Address)

15 Filed FEB 5 1924, 19

Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Feb 5, 1924,

that I last saw her alive on Feb 5, 1924,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcohol

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Fred D. Allen, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calhoun S. C

DATE OF BURIAL 2/5 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83481

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83481

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter A. Raines.

(a) RESIDENCE No. 1427 Henry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ---mos.----ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced HUSBAND of ~~XXXXXXXXX~~ ~~XXXXXX~~ Dora C. Raines.

6 DATE OF BIRTH (month, day, and year) March 14, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Switch man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Robert Raines.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary L. ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Dora C. Raines. (wife)
(Address) 1427 Henry St.

15 Filed ....., 192 Robert F. Harrison, Registrar
5-1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Muriatic Acid poisoning.
Suicide.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Feb. 3, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or io deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? 1427 Henry St. February 2, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem.	Feb 6 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light

CAUSE SHOULD BE STATED EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83482

D 83482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 38 N. 11th St., 6 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan E Lewis

(a) Residence No. 38 N 11st St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: R. E. Lewis

6-DATE OF BIRTH (month, day and year): Dec 26 1854

7-AGE: 69 yrs. / mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Frederick Maryland

PARENTS.

10-NAME OF FATHER: W Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14- (Informant): Mrs Fannie L Pierce
(Address): 38 N 11th St Highlandtown

15-

Filed ..... 192 ..... Albert F. Harris Registrar.

FEB 5 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 4 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1st 1923 to Feb 4 1924 that I last saw her alive on Feb 3 1924 and that death occurred, on the date stated above, at 8.35 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Uterine Sclerosis

(Duration) — yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Verner H. Carden M. D.

, 19 (Address) 750 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Oak Lawn	Feb 7 19.24
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every name and word should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83483

CERTIFICATE OF DEATH.

162 D 83483

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S Sharp St., 27 WARD)

2-FULL NAME Parents Ashley Lee Bell & Rosalie Porter

(a) RESIDENCE NO. 320 S Sharp ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2.4.24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.
	9th Dorsal	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Ashley Lee Bell

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Madison Co Va

12 MAIDEN NAME OF MOTHER Rosalie Porter

13 BIRTHPLACE OF MOTHER (city or town) Cambridge
(State or country) Md

14 Informant Ashley Lee Bell
(Address) 320 S Sharp St

15 FEB 5 - 1924, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.4 1924

17 I HEREBY CERTIFY, That I attended deceased from 2.4, 1924, to 2.4, 1924, that I last saw him alive on 2.4, 1924, and that death occurred, on the date stated above, at 2.50 a m.

The CAUSE OF DEATH* was as follows:

Dysentery

Birth (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) L. T. Worthington M. D.

, 19 (Address) 107 E 70th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 6 1924
20 UNDERTAKER	ADDRESS
John H. Denny	715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 83484 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 83484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3213 Westwood Ave., St., 15 74 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul M. Grabow, (Grabow)

(a) Residence No. 3213 Westwood Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male,

4-COLOR OR RACE, White,

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary R. Grabow

6-DATE OF BIRTH (month, day and year) Apr 3, 1848

7-AGE, 75 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Physician

(b) General nature of industry, business, or establishment in which employed (or employer). Retired. 054

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS

10-NAME OF FATHER Herman Grabow

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-Mrs. Mary R. Grabow
(Informant)
(Address) 3213 Westwood Ave

15- Robert P. Harrison,
Filed ..... 192.....
Registrar.

FEB 5 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from December, 1923, to Feby 3rd, 1924, that I last saw h. alive on Feby 3rd, 1924, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Acute Asphyxia.
(Duration) yrs. mos. 1 dy.

CONTRIBUTORY (Secondary) Aches Sclerosis.
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Sig.) Amy Coulton, M. D
2/4/1924 (Address) 3303 Windsor Mill Rd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL, Feb 6, 1924

20-UNDERTAKER: Wm J. Fichter & Sons ADDRESS North & Pa Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83485

CERTIFICATE OF DEATH.

49 D 83485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Municipal Tuberculosis Hospital ST., 4 WARD)

2-FULL NAME James Moore

(a) RESIDENCE NO. 759 W. Fayette st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Weighman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert J. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Caroline Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 5 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1923 to Feb. 5, 1924, that I last saw him alive on Feb. 5, 1924, and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Neck

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Terminal broncho pneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological section

(Signed) L. A. Lally, M. D.

2-5-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 2/7 1924

20 UNDERTAKER Wm. J. Ficken & Sons

ADDRESS north & Dennard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

O.K. - A.S.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83486

CERTIFICATE OF DEATH.

D 83486

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 256 South Gun ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael F Eagan

(a) RESIDENCE NO. 256 South Gun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 Sex Male

4 COLOR OR RACE White White

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Eagan

6 DATE OF BIRTH (month, day, and year) July 27-1860

7 AGE Years 64 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) American 062

(c) Name of employer Beaz Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Eagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Katherine Eagan (Address) 256 S. Gun

15 Filed Robert P. Harrison, Registrar

FEB 5 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 19 24

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 19 24 to Feb 4, 19 24

that I last saw him alive on Feb 3, 19 24

and that death occurred, on the date stated above, at 805 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Keller, M. D.

2/5, 19 24 (Address) 1937 South St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland

DATE OF BURIAL 2/7 19 24

20 UNDERTAKER Wm Cook

ADDRESS 501 N Gilmor

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 83487 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 83487

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Mary Turner.

(a) RESIDENCE No. 918 W. Lexington ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	45			

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) Lynchburg (State or country) Virginia

PARENTS

10 NAME OF FATHER Delaware Turner

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Anna Shelton

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 FEB 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1924, to Feb. 4, 1924, that I last saw her alive on Feb. 4, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus.

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tubo-ovarian abscess. Prolapsus uteri. Bilat. (duration) ..... yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes. Date of Jan 17, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Henry L. Danner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lynchburg Va	2-6-19 24
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83488

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Rhoades

(a) RESIDENCE NO. 547 Oxford ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. Life mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: — Months: 8 Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Mary Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 FEB 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Feb 4, 1924.

that I last saw h.e alive on Feb 4, 1924

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. T. Bruce, M. D.

19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1-6 1924

20 UNDERTAKER: Wm. Fairbrother

ADDRESS 916 Park Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

LOBAR

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83489

CERTIFICATE OF DEATH.

D 83489

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 Poca St., Mt Winans Ward) 25

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Monroe

(a) Residence No. 27 Poca St., Mt Winans Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colo

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1882

7-AGE, (yrs. 42 mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Do

PARENTS.

10-NAME OF FATHER, Frank Monroe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Harriet Townsend

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Francis Bagley

(Address) 1217 Shields Alley

FEB 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 1 1924 to Feby 1 1924, that I last saw h.r alive on Feby 1 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Hall M. D

, 19 (Address) Halethorp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL, 2-6- 1924

20-UNDERTAKER, Enid Easton — ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002D 83490

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1719 W. Franklin ST. 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Butler

(a) RESIDENCE NO. 1719 W. Franklin ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male Boy

4 COLOR OR RACE Cul

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1923

7 AGE Years Months 7 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER King Butler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Dollie Washington

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Dollie Washington
(Address) 1719 W. Franklin

15 FEB 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Feb 4, 1924, that I last saw him alive on Feb 4, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lafrippe

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Coleman M. D.

(Address) 2038 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Feb 6 1924

20 UNDERTAKER R. Gross — ADDRESS 1405 McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83491

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83491

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1543 Glenwood Ave. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Douglass E. Balderston

(a) Residence No. 1543 Glenwood Ave. St., 13 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 1-1924

7-AGE, — yrs. 1 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, J. Wm. Balderston

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER, Oda M. Case

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14-(Informant) J. Wm. Balderston

(Address) 1543 Glenwood Ave

15-FILED FEB 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 5-1924

17-I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1924, to Jan. 5, 1924, that I last saw him alive on Jan 5, 1924, and that death occurred, on the date stated above, at 12-15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical Signs

(Signed) C. F. Conzelman M. D.

2/5, 1924 (Address) # 3701 Loud Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. St. Mary's (Pamplin) DATE OF BURIAL, Feb. 7, 1924

20-UNDERTAKER. Horace H. Burgee ADDRESS 3631 Falls Road

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83492

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 E. Oliver Street St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Sonderman

(a) Residence No. 1709 E. Oliver Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Philip Sonderman

6-DATE OF BIRTH (month, day and year) 7/12 1852

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Wm Sonderman

(Address) 1709 E. Oliver St

15- FEB 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to Feb 4 19 24

that I last saw h... alive on Feb 4 19 24

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Endocarditis Chronic.

Duration 7 yrs 1 mos

CONTRIBUTORY (Secondary) Senile Debility 7 yrs 1 mos

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? none

(Signed) Chas E. Schlueter M. D.

2/5, 1924 (Address) 403 E. Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. 2/7 1924

20-UNDERTAKER. George J. Ruth

ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83493

CERTIFICATE OF DEATH.

100-001

100 D 83493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4170 Belair Road ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Lohmeyer

(a) RESIDENCE No. 4170 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest J. Lohmeyer

6 DATE OF BIRTH (month, day, and year): 9 15 1874

7 AGE: 49 (Years) (Months) (Days) If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Faul

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Caroline Eckerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Ernest J. Lohmeyer

(Address): 4170 Blair Road.

15 Date Received: FEB 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 3, 1924, that I last saw h[illegible] alive on Feb 2, 1924, and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

Bronchitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma & Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Bruiser, M. D.

Feb 4 1924 (Address) 4 W Hoffman Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Luth Cemetery DATE OF BURIAL: 2/6 1924

UNDERTAKER: George J Ruth ADDRESS: 1735 Harford Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83494

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 33494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Shelter for Aged Colored Persons St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Parker

(a) RESIDENCE. No. Shelter for Aged Colored Persons ST. ..... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Parker Dont Know

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Matron (Address) Shelter for Aged Colored Persons

15 FEB 6 - 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to Feb. 4, 1924, that I last saw h[illegible] alive on Feb. 3, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. F. Carr, M. D.

, 19 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel [illegible]	Feb. 6 1924

20 UNDERTAKER Chas. E. Fraser ADDRESS 501 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83495

CERTIFICATE OF DEATH.

38

D 83495

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N Bethel ST., 6 WARD)

2-FULL NAME Maria Gutheright

(a) RESIDENCE No. 430 N Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10, 1887

7 AGE — Years: 36 Months: 6 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ~~Balto~~ Va

PARENTS

10 NAME OF FATHER: John Gutheright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mary E King (mother)

(Address) 430 N Bethel St

FEB 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1924

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to Feb 2, 1924, that I last saw h alive on Feb 2, 1924, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis of Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. D. Lyon, M. D.

2/2 1924 (Address) 1 Mey E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: 2/6 1924

20 UNDERTAKER: Robert Williams

ADDRESS: #1575 Mc Elderry St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis
Wassermann
Called (†) Health Dept

Spec. 1M 12-23 (3577)—1500 Bks.

D 83496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83496

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2725 Presbury ST., 15 WARD)

2-FULL NAME August R. Engren

(a) RESIDENCE NO. 2725 Presbury ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ Elizabeth

6 DATE OF BIRTH (month, day, and year) Dec 8 1865

7 AGE: Years 58 | Months 1 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood-finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Piano Case

(c) Name of employer Chas. Parker & Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Engren (Address) 2725 Presbury

15 Filed FEB 6 - 1924 ROBERT H. KRAUER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I attended deceased from October 19th 1923 to February 2nd 1924.

that I last saw h[illegible] alive on February 2nd 1924.

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

Apparently (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard Lyon Rey M. D.

2/7, 1924 (Address) 5306 North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 7. 1924

20 UNDERTAKER: Fickler & Fickler — ADDRESS 1137 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83497

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Mount Hope Retreat ST. 28 WARD)

2-FULL NAME Catherine Francis Sindall

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, ~~Husband~~ of (or) WIFE of Mr Sindall

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Joseph F. McClellan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah F. Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Retreat.

FEB 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 15 1923 to Feb. 5. 1924,

that I last saw h Er alive on Feb. 4 1924;

and that death occurred, on the date stated above, at 2.20 a m.

The CAUSE OF DEATH* was as follows:

Softening of Brain — Chronic —

Post Cerebral Hemorrhage.

(duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Psychosis.

(duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Feb. 8 1924
20 UNDERTAKER Gerkler & Gerkler	ADDRESS 1739 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83498 | 129 | D 83498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 E Eager ST. 10 WARD)

2-FULL NAME Rev. Paul Huber. b. S. S. R.

(a) RESIDENCE NO. 1225 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Sing'l.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergy. 018

(b) General nature of industry, business, or establishment in which employed (or employer) Redemptorist Priest

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Pole

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Rev. Giles J. Ynestein Rector St James Church 1226 Eager St

15 Filed FEB 6 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feburay 5 1924

17 I HEREBY CERTIFY, That I attended deceased from at period from Oct 1923 to date 19.... to 19.... that I last saw him alive on Feby 4 1924, and that death occurred, on the date stated above, at 5-25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Unknown (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic coma (duration) a few hours yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. A. Obrien, M. D.

1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Feburay 8 1924

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

dr Kimzey 2700 Harford Road
Normund 11541

HEALTH DEPARTMENT—CITY OF BALTIMORE

83499

CERTIFICATE OF DEATH.

27 74-001

D 83499

Registered No.....

1-PLACE OF DEATH 2925 Bellona Ave

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M Harrison

(a) Residence No. 2925 Bellona Ave St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Albert N Harrison

6-DATE OF BIRTH (month, day and year) Oct 22. 1854

7-AGE	If LESS than 1 day,
69 yrs. 2 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, Archer McNeir

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Md

12-MAIDEN NAME OF MOTHER, May J Hall

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Md

14-(Informant) Albert N Harrison

(Address) 2925 Bellona Ave

15- ROBERT R. KRAUTER, Registrar.

FEB 6 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 5. 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1923 to Feb 5 1924

that I last saw h[illegible] alive on Feb 5 1924

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Kimzey, M. D

19 (Address) 2700 Harford Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb 8 1924

20-UNDERTAKER	ADDRESS
Wm Cook	502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83500 ✓ D 83500

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3717 Eastern Ave ST., 76 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Booth

(a) RESIDENCE No. 3717 Eastern Ave. ST., 76 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A. Booth

6 DATE OF BIRTH (month, day, and year) Aug. 5 - 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Capper

(b) General nature of industry, business, or establishment in which employed (or employer) Canning Industry

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER William Booth

11 BIRTHPLACE OF FATHER (city or town) Wash. (State or country) D. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Wash. (State or country) D. C.

14 Informant (Address) John T. Booth 3717 Eastern Ave (Son)

FEB 6 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Feb 4, 1924.

that I last saw him alive on Feb 4, 1924

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Exam.

(Signed) Geo Clinton Blades, M. D.

(Address) 1432 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Feb. 6 1924.

20 UNDERTAKER Lilly & Feiser.

ADDRESS 1103 N. Holl St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Streat

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 33501

CERTIFICATE OF DEATH.

D 33501

1-E 23
1-E
804

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 W. Mechanic St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ora Streat

(a) RESIDENCE No. 552 W. Mechanic ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER C. L. Streat

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Alma Hankins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): La

14 Informant: Christopher Streat

(Address) 552 W. Mechanic St

15 FILED FEB 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5/24 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Feb 5, 1924.

that I last saw h. alive on Feb 5, 1924,

and that death occurred, on the date stated above, at 1225 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. W. O. Robinson, M. D.

2/5, 19 24 (Address) 1526 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 2/7 1924

20 UNDERTAKER: Hammond & Leigh — ADDRESS: 536 N. Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 83502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83502

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Skinner

(a) Residence No. 773 Sarah Ann St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2wk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1849 (?)

7-AGE. 75 (?) yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel Tillman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Dorothy Peck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records

(Address)

FEB 6 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 2 19 24 to February 2 19 24

that I last saw h. er alive on February 1 19 24

and that death occurred, on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis (Degenerative)

Myocardial Insufficiency

(Duration) yrs. 2 mos. (Estimated)

CONTRIBUTORY (Secondary) Myocardial Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude J. Thomas M. D

2-2- 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 2/6 1924
20-UNDERTAKER, Henry Blum	ADDRESS 758 Dolphin

Hamf

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83503

D 83503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer Hospital ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian May Heller

(a) RESIDENCE. NO. 2504 W. Fairmount ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Wm Heller.

6 DATE OF BIRTH (month, day, and year) July 21, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. Richter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Frank.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Chas W. Heller

(Address) 2504 W Fairmount Ave

FEB 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1924, to Feb. 2, 1924.

that I last saw h[illegible] alive on Feb. 2 1924.

and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Morphine Poisoning

Idiosyncrasy to morphine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Idiosyncrasy to morphine (duration) yrs. mos. days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 2, 1924

Was there an autopsy? no Basilar dony + Submucous resection

What test confirmed diagnosis?

(Signed) Franklin B Anderson M. D.

. 19 (Address) 10 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 6 1924
20 UNDERTAKER	ADDRESS
Harry J Witzke	1531 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE... PHYSICIANS SH... mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... may be ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83504

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 N. Calvert Street ST., 12 WARD)

2-FULL NAME MARY ELIZABETH HEBB

(a) RESIDENCE No. 2105 N. Calvert Street ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 50 yrs. 8 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): May-17-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): St. Marys County Maryland

PARENTS

10 NAME OF FATHER: Griffin Hebb

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Marys Co. Maryland

12 MAIDEN NAME OF MOTHER: Betty Cecelia Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Marys Co. Maryland

14 Informant: Mrs. Emily Jeantte Scaffee (sister)
(Address) 208 E. 20 Street

15 FEB 6 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1922. to Feb 5. 1924.
that I last saw her alive on Feb 5. 1924
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 18 mos
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Ch. Bagley, M. D.

19 (Address) 2805 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 8 1924

20 UNDERTAKER: [illegible] & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

Spec.—1-10-21—M&T—1500 Bks.

D 83505

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Linden Avenue ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME SAMUEL KEENER HARRISON

(a) RESIDENCE NO. 1312 Linden Avenue ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 59 yrs. 6 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Harrison

6 DATE OF BIRTH (month, day, and year) July-20-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	59	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant 046

(b) General nature of industry, business, or establishment in which employed (or employer): Groceries

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Talbot County Maryland

PARENTS

10 NAME OF FATHER: Theo.P Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co. Maryland

12 MAIDEN NAME OF MOTHER: Maria Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs. Nancy Harrison (wife)

(Address) 1312 Linden Avenue

15 FEB 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4- 1924

17

I HEREBY CERTIFY, That I attended deceased from Jany 29th, 1924, to Feb 4th, 1924,

that I last saw h— alive on Feb 4th, 1924,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Val Bro. Pneumonia (Initial)

(duration) Feb 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Wm. Wilson, M. D.

, 19 (Address) 607 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Feb-6-24.

20 UNDERTAKER: HART & MOWEN COMPANY

ADDRESS: 108 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 83506

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-0 83506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 Harvey ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl C. Madkin

(a) RESIDENCE NO. 639 Harvey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 7, 1923

7 AGE: Years — Months: 3 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Edw. Madkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER: Virginia Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Mary's Co. Md.

14 Informant: Edw. Madkin

(Address): 639 Harvey St.

FEB 6 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1924, to Feb 5, 1924.

that I last saw him alive on Feb 4, 1924

and that death occurred, on the date stated above, at 12-30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ephanetus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co.

DATE OF BURIAL: Feb. 6 24

UNDERTAKER: Margaret S. Flynn

ADDRESS: 1411 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND REGISTRATION BLANKS

Spec.—1-10-21—M&T—1500 Bks.

LOUGHRAN D 83567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83507

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

2-FULL NAME Isabella Loughran.

(a) RESIDENCE NO. 616 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
70 +				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs Emma B. Davis 2623 Shirley ave.

15 Filed FEB 6 1924 19.... ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

I HEREBY CERTIFY, That I attended deceased from January 30, 1924, to Feb 5, 1924.

that I last saw she alive on Feb 5, 1924.

and that death occurred, on the date stated above, at 1.00 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency;

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus;

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Shennick, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Feb. 7 1924

20 UNDERTAKER Margaret A. Flynn — ADDRESS 1422 Light St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Bks.

D 83508 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83508

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1829 Lemmon St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella L. Towson

(a) Residence No. 1829 Lemmon St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Samuel F. Towson

6-DATE OF BIRTH (month, day and year) Dec 18th 1887

7-AGE. 36 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Samuel C. Halfpenny

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Samuel F. Towson

(Address) 1829 Lemmon st

15- Filed FEB 6 - 1924 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 4th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1923 to Feb 3 1924

that I last saw her alive on Feb 3 1924

and that death occurred, on the date stated above, at 1055 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Myocardial Insufficiency

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis (Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Positive Sputum Examinat

(Signed) Louis H. Krumrei M. D.

, 19 (Address) 722 N. Kenwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	Feb 7th 1924
20-UNDERTAKER	ADDRESS
Gu. Weber & Son	2503 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83509

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 E. LaFayette Ave. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

74-001 ✓

D 83509

Registered No.

2-FULL NAME.... Jacob Ziff

(a) Residence No. 1509 E. LaFayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Ziff

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Grocery

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-

(Informant) J. Lewis

(Address) 1439 E. Balto. St.

15-

Filed 192

ROBERT R. KRAUTER, Registrar.

FEB 6 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 2-5-24

17- I HEREBY CERTIFY, That I attended deceased from January 30 19 24 to February 5th 19 24

that I last saw him alive on February 5th 19 24

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

4 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

6 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and

Signed H. Lewis M. D.

2/6 19 24 (Address) 1031 N. Carrollton Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Wash. Road

DATE OF BURIAL, Feb 7-, 19 24

20-UNDERTAKER: Jac Lewis

ADDRESS 1439 E. Balto. St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83510

CERTIFICATE OF DEATH.

179 D 83510

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 404 N. Rose St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jacob Leyh

(a) Residence No. 404 N. Rose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 12/19/1901

7-AGE. 22 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Brass Finisher

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 010

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Leyh

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Minnie Leopold

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14- (Informant)..... John Leyh

(Address)..... 404 N. Rose St

15- Filed FEB 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/3/1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 19 24 to Feb 3 19 24

that I last saw him alive on Feb 2 19 24

and that death occurred, on the date stated above, at 7 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

abrout 3 (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) bronchopneumonia

(Duration)..... yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edward Novak M. D.

, 19 (Address) 76 E. Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mathews Cem — DATE OF BURIAL. Feby 8 1924

20-UNDERTAKER. John Zellerbach — ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 83511

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Mc Elderry ST.; 7 WARD)

2-FULL NAME Rita Bender

(a) RESIDENCE. NO. 2600 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) July 27 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank Bender

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Lennon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Frank Bender
(Address) 2600 Mc Elderry St

15 FEB 6 1924 ROBERT K. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924, to Feb 6, 1924, that I last saw h w alive on Feb 5, 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Erysipelas (Face)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam B Leuman, M. D.

, 19 (Address) 718 N. Pat Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 8 1924
20 UNDERTAKER	ADDRESS
Frank Enoch & Son	1906 Eblana

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause unknown

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83512

CERTIFICATE OF DEATH.

74-001 ✓ D 83512

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 N. Collington Av St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Kabista

(a) Residence No. 903 N. Collington Av St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced, HUSBAND of (or) WIFE of Mary Kabista

6-DATE OF BIRTH (month, day and year) Dec 26/1868

7-AGE. 55 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER Bernard Kabista

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mary Mary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

11- (Informant) Mary Kabista

(Address) 903 N. Collington Av

15- FILED FEB 6 - 1924 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 5/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to Feb 5 19 24

that I last saw h.. alive on Feb 5 19 24

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) Wm [illegible] M. D.

Feb 6 19 24 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Feb 9 19 24
20-UNDERTAKER.	ADDRESS
Fred Crockson	1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83513 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 83513

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2910 Elliott ST.: 1 WARD)

2-FULL NAME Frances Nitka

(a) RESIDENCE. No. 2910 Elliott ST., WARD. 1ST

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanley

6 DATE OF BIRTH (month, day, and year) Dec 31 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Klucinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Wisniewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanley Nitka (Address) 2910 Elliott St

15 Filed ... 19 Robert P. Harrison, Registrar

FEB 6 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1923, to Feb 4, 1924, that I last saw her alive on Feb 4, 1924, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bronushas, M. D.

2-5 1924 (Address) 3037 Ordnance St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross German Hill Road

DATE OF BURIAL Feb 7 1924

20 UNDERTAKER Wendell Dypple & Son

ADDRESS 378 N

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Chester 1504 McCulloh
Med 1568

83514

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83514

1-PLACE OF DEATH Wyndhurst and Laurence Aves. 27

Registered No.....

City of BALTIMORE: (No.....St., 27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME David A Dixon

(a) Residence No. Wyndhurst and Laurence Aves. Rolland Park St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Mary A Dixon

6-DATE OF BIRTH (month, day and year) Sept 28. 1854

7-AGE, 69 yrs. 4 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boiler Maker Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Samuel Dixon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Isabella Armstrong

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Scotland

11- (Informant) Robert H Dixon

(Address) Wyndhurst and Laurence Ave.

15-

Filed FEB 6 - 1924 Robert L. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 24 1924 to Feb 5 1924

that I last saw h.. alive on Feb 5 1924

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

2 yrs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

2

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. F. Alexander M. D.

Feb 6 19 (Address) 1504 McCulloh St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount, Md. DATE OF BURIAL, Feb 7, 1924

20-UNDERTAKER, Wm Cook ADDRESS 502E Pratt Ave.

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 83515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83515

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2735 Tivoly ave St. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Elizabeth White Lancaster

(Residence in Baltimore: No. 2735 Tivoly Ave. St.; yrs. 5 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White American

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 21, 1874 (Month) (Day) (Year)

7-AGE, 49 yrs. 10 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Nathaniel S. White

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Du Shane

13-BIRTHPLACE OF MOTHER (State or Country), Winchester Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard L Lancaster

(Address) Reisterstown Md

15-

Filed ..... 191.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 5th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1923, to Feb 5th 1924, that I saw her alive on Feb 4 1924 and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

(Carcinoma of left breast not operated on, resulted in) Carcinoma of Liver

..... (Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma breast

..... (Duration) 1 yrs. 6 mos. ds.

(Signed) P. S. Bandaran-Susca M. D.

Feb 5, 1924 (Address) 1315 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olive Cemetery Randallstown

DATE OF BURIAL. Feby 7th, 1924

20-UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument st

Spec.—1-10-21—M&T—1500 Bks.

D 83516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83516

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 N. Eden ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Reed Jenkins

(a) RESIDENCE NO. 1410 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Lydia E Jenkins

6 DATE OF BIRTH (month, day, and year) Dec 25th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer) Union Trimming Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kingston Canada

PARENTS

10 NAME OF FATHER Wm David Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Rachel Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) Mrs Franklin E Becker 1410 N Eden st

15 Filed FEB 6 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5th 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan , 1920 , to Feb 5 , 1924 , that I last saw him alive on Feb 5 , 1924 , and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hubert C Knapp , M. D.

Feb 6 1924 (Address) 1216 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cemetery DATE OF BURIAL Feby 8th 1924

20 UNDERTAKER George S Lilling & Sons ADDRESS 1126 E Mount St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PHOTOSTAT

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 83517 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-09 D 83517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 802 W. Ostend St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Patton

(a) Residence No. 802 Ostend St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Blk 5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 5-24

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 20 hrs. ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Dan Patton

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Charlotte NC

12-MAIDEN NAME OF MOTHER Betty Mitchell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Charlotte NC

14- (Informant) Dan Patton

(Address) 802 Ostend St

15- Filed ..... 192.. Robert P. Harrison, Registrar.

April Perrit Clerk.

FEB 6 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-5-24

17- I HEREBY CERTIFY, That I attended deceased from 2-25-24 to 2-5-24

that I last saw h[illegible] alive on 2-5-24

and that death occurred on the date stated above at 8:30 a.m.

The CAUSE OF DEATH was as follows: Exhaustion

Premature Birth

20 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. G. Schwaenberg M. D.

(Address) 1126 W Lex St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL, Feb 7 1924

20-UNDERTAKER. P C Gross ADDRESS 1405 McElderry

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83518 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 83518

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Banks

(a) RESIDENCE NO. 2502 E. Balto St. St., ... Ward West Friendship Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Sept 30/24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Howard Co. Md

PARENTS

10 NAME OF FATHER: Earl Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Grace Moxley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md.

14 Informant: C. H. Weer
(Address): Sykesville Md.

Filed FEB 6 1924 192 Robert F. Marriam, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to hos death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Peritonitis-Probably Pneumococcis and probably Blood Stream blood stream infecti on.
(Autopsy at Hopkins) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) G. H. Weer, M. D. (Coroner.)

Feb 6/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs., ...mos., 1 ds. In the State ....yrs., 4 mos., ...

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. View Md	Feb. 8 1924
20 UNDERTAKER: J. R. Weer	ADDRESS: Sykesville

Howard Co. Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificate.

Streptococcus hemolyticus

(Streptococcus)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether [illegible] is directly or indirectly due to same.

Spec—12-23-21—L.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83519

83519

CERTIFICATE OF DEATH.

36-005

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 433 S. Parrish Street St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Gerhart Dietrich Schmidt

(a) Residence No. 433 S. Parrish St. St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Flora A. Schmidt

6-DATE OF BIRTH (month, day and year) Sept. 25, 1849

7-AGE. 74 yrs. 4 mos. 10 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Butler at Alma

(b) General nature of industry, business, or establishment in which employed (or employer). Button Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Mrs. Flora A. Schmidt

(Address) 433 S. Parrish Street

15- Filed FEB 6 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 19 24, to Feb 4 19 24, that I last saw him alive on Feb. 4 19 24, and that death occurred, on the date stated above, at 3.55 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis right Kidney

(Duration) yrs. 3 mos.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jas. T. Hennessy. M. D.

2-4, 19 24 (Address) 2802 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Feb 7, 1924
20-UNDERTAKER.	ADDRESS
Jas Bloodwell	503 W Baltimore

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83520

CERTIFICATE OF DEATH.

129 D 83520

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Rennert ST.: 4 WARD)

2-FULL NAME William Alexander Key

(a) RESIDENCE. No. Hotel Rennert. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodstock
(State or country) Maryland

PARENTS

10 NAME OF FATHER Horace M. Key

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Harriet N. Conway

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Pauline Cavey
(Address) 114 W. Franklin St.

15 Filed ....., 19.. Robert P. Harrison, Registrar

FEB 6 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1923 to Feb 5, 1924
that I last saw him alive on Feb. 3, 1924,
and that death occurred, on the date stated above, at 7.45 P m.
The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Woodstock Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam of Heart & Urine

(Signed) Harry F. Shipley, M. D.

2/6, 1924 (Address) Woodstock Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock Md.	Feb 8 1924

20 UNDERTAKER Jos Block ADDRESS 1003 N Balto St

MARGIN RESERVED FOR BINDING

NK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83521

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No.) Maryland Lying-in Hosp (St.) John Mulcher (Ward)

2-FULL NAME Maryleen Muhlenberg

(a) RESIDENCE No..... St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) Minnesota
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant .....
(Address)

15 Filed FEB 6 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to wounds of chest produced by a bullet in hands of unknown person (duration) ..... yrs. ..... mos. ..... ds. Homicidal

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) William Ruby, M. D.
(Coroner.)
Feb 6, 1924 (Address) 16 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., 4 mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Philadelphia Pa

DATE OF BURIAL July 7th 1924

20 UNDERTAKER George D Sullivan & Son

ADDRESS 112 S Howard St

Spec.—1-10-21 M&T 1500 Bks.

168035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83522

CERTIFICATE OF DEATH.

90 D 83522

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary a Conegys

(a) RESIDENCE NO. 1123 E. Hoffman ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Marion J. Conegys

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	—	— —	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Farr

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Magdalena Zellers

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

FEB 7 - 1924

ROBERT R. KRAUTER, Registrar,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1923, to Feb 5, 1924, that I last saw he alive on Feb 5, 1924, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Auricular fibrillation

Hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Edema of lungs, liver & kidneys, Pleurisy, Pneumonia, Heart disease and renal disease

(duration) ..... yrs. 9 mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Edema right leg - heart

(Signed) Walter E. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery Hampden	Feb. 8 1924
20 UNDERTAKER	ADDRESS
Henry Hoch Son	1901 E Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83523

CERTIFICATE OF DEATH.

6 100-001

D 83523

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Durham ST., ... WARD)

2-FULL NAME Laura Mitchell

(a) RESIDENCE No 2012 Lincoln Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (late) Richard Mitchell

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) (Family)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Margaret Weaver (niece)
(Address) 213 N. Durham St.

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar.
FEB 7 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(Primary)

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wales, M. D.
(Coroner.)

Feb 5/24 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb. 6th 1924

20 UNDERTAKER E. Milton Travis ADDRESS 315 N. Eden St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83524
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2325 Milliman St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna J. Cline

(a) Residence No. 2325 Milliman St., 7 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Cline

6-DATE OF BIRTH (month, day and year) April 12, 1869

7-AGE. 55 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Andrew E. Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anne J. Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), York Pa

11- (Informant) Mrs. Charles Waldhausen

(Address) 2325 Milliman St.

FEB 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 5/24

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924, to Feb 5, 1924, that I last saw h[illegible] alive on Feb 4, 1924, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

Nephritis (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Lennard, M. D.

2/7/24 (Address) 718 N Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Feb. 8, 1924
20-UNDERTAKER.	ADDRESS
William G. Schaeffer	1816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Bks.

Reeves

D 83525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 83525

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 353 Canal alley St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florance Reeves

(a) Residence No. 353 Canal alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred not known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1889

7-AGE 35 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER David Eason

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Eason

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Md

14-

(Informant) David Easton

(Address) 916 Pine

FEB 7 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 6 1924

17- I HEREBY CERTIFY, That I attended deceased from January 30 1924 to July 6 1924

that I last saw her alive on July 1 1924

and that death occurred, on the date stated above, at 8:16 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

2/6, 1924 (Signed) Paul Ewing M. D.

(Address) 6006 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	2-7-24
20-UNDERTAKER David Easton	ADDRESS 916 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83526

CERTIFICATE OF DEATH.

D 83526

1823 57 1869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 Bruce ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Forester

(a) RESIDENCE NO. 812 Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER Benj. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford Co. Md

12 MAIDEN NAME OF MOTHER Mary Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mitchell & Ruppler

(Address) 1508 Presstman St

15 FEB 7 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1924, to Feb. 5, 1924, that I last saw h[illegible] alive on Feb. 5, 1924, and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH* was as follows:

Leukemia

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

2/6/ 1924 (Address) 1522 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arnold Station DATE OF BURIAL Feb 8th 1924

UNDERTAKER Thomas E. Wright ADDRESS 1562 McCaul St

Cemetery Mt Cairy.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83527

CERTIFICATE OF DEATH.

D 83527

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Gilmor ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion L. Watkins

(a) RESIDENCE NO. 1631 Gilmor ST., WARD Calvert Co Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mattie Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mamie Markel
(Address) 1631 Gilmor St

15 FEB 7 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/21, 1924, to 2/5, 1924,
that I last saw h[er] alive on 2/5, 1924,
and that death occurred, on the date stated above, at 12[39] A m.

The CAUSE OF DEATH* was as follows:

(a) Nephritis
Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhardt, M. D.

2/6, 1924 (Address) 2139 Dd. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Station Catonsville	Feb 8th 1924

20 UNDERTAKER Samuel Enright ADDRESS 1364 N Carey

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Grippe

Cor.—1-12-23—M&T—100 Bks.

D 83528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-006 ✓ 188 D 83528

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secour Hospital ST., 16 (WARD)

2-FULL NAME John W. Hanes

(a) RESIDENCE No. 913 E Pursit ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Elyn Hanes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... old
(b) General nature of industry, business, or establishment in which employed (or employer) Labor
(c) Name of employer R P Dobson

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Dont Known

12 MAIDEN NAME OF MOTHER Jane Harden

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Earl H. Hanes
(Address) 1020 Mount St

15 FEB 7 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident

Multiple Fractured

(duration) ..... yrs. ..... mos. 5 hrs. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. 3 ds.

(Signed) Geo Clinton Black, M. D.
(Coroner.)

Feb 4, 1924 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem

DATE OF BURIAL Feb 8 1924

20 UNDERTAKER John De Coursey

ADDRESS 530 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83529

CERTIFICATE OF DEATH.

88 D 83529

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N Gilmor ST., 19 WARD)

2-FULL NAME William Howard

(a) RESIDENCE NO. 418 N Gilmor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 16, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	2	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard County Md

PARENTS

10 NAME OF FATHER Sol Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Raymond Clarke
(Address) 418 N Gilmor

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1924, to Feby 3, 1924, that I last saw him alive on Feby 3, 1924, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerative Endocarditis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Hamilton, M. D.

(Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery — DATE OF BURIAL Feb 7 1924

20 UNDERTAKER John F Owens — ADDRESS 538 Dolphin

Spec.—1-10-21—M&T—1500 Bks.

Upshur

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83530

CERTIFICATE OF DEATH.

129

D 83530

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 712 ~~Jennie Upshur~~ N. Carey ST., 10 WARD)

2-FULL NAME Jennie Upshaw

(a) RESIDENCE No. 712 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abel Upshaw

6 DATE OF BIRTH (month, day, and year) Dec 12-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	71	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wheeling W Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lucy Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wheeling W. Va

14 Informant Lolita Johnson

(Address) 712 N. Carey St

15 Filed FEB 7 - 1924, 19.. ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to Feb 5, 1924

that I last saw h[illegible] alive on Feb 4, 1924

and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Ch. Chiefs Colored Mutual Benefit

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted, if not at place of death? [illegible] Place [illegible]

Did an operation precede death? [illegible] Date of

Was there an autopsy? [illegible]

What test confirmed diagnosis? [illegible]

(Signed) Walter T. Jones, M. D.

, 19 (Address) 16 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brancock Va

DATE OF BURIAL Feb 8 1924

20 UNDERTAKER John R. Owens

ADDRESS 539 Dolphin St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 83531

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245 N Luzerne ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Dunn

(a) RESIDENCE NO. 245 N Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda M Dunn

6 DATE OF BIRTH (month, day, and year) August 25-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Govt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George W Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Matilda Dunn

(Address) 245 N Luzerne st

15 Filed FEB 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924, to Feb 4, 1924.

that I last saw he alive on " " 1924

and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

17a CONTRIBUTORY (Secondary) Chronic Bright's Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A C Beam, M. D.

2/5, 1924 (Address) 3907 Fairview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Feb 7th 1924
20 UNDERTAKER	ADDRESS
Geo C. Miller	2334 Jefferson St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83532

CERTIFICATE OF DEATH.

74-001

D 83532

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Pidler op Pr Sts., 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Susan Robinson

(a) Residence No.... Preston & Valley Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, ~~Married,~~ Widowed, or ~~Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1856

7-AGE. 68 yrs. mos. dls. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Odd

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Frederick Co. Md

PARENTS.

10-NAME OF FATHER, X

11-BIRTHPLACE OF FATHER (city or town) (State or Country). X

12-MAIDEN NAME OF MOTHER, X

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). X

14- (Informant) Sister Florence

(Address) Preston & Valley

15- Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby 6 1924

17- I HEREBY CERTIFY, That I attended deceased from No Record, 19... to... 19...

that I last saw h... alive on... 19...

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 1 day ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Feby (Signed) F. A. Warner, M. D

, 19 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Feb 7, 19 23

DATE OF BURIAL.

20-UNDERTAKER. H. C. Wiedefeld

ADDRESS 614 Greenmount ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

83533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83533

Registered No. 74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 3301 First ave St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David P. Trow

(a) Residence No. 3301 First ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. d. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Helen K. Trow

6-DATE OF BIRTH (month, day and year) Dec. 5-1890.

7-AGE. 33 yrs. 2 mos. — ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Oil Refining

(c) Name of employer: Oil Co.

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frederick Trow

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary L Shipling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Helen K. Trow

(Address) 3301 First ave

15- Filed FEB 7 1924 ROBERT B. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 5-1924.

17- I HEREBY CERTIFY, That I attended deceased from June 21st., 1924 to Feby 5th., 1924 that I last saw h alive on Feby 4th., 1924 and that death occurred, on the date stated above, at 10.15 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage. Apoplexy

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D W Wells, M. D.

2-6-, 1924 (Address) 1011 N Ellwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore — DATE OF BURIAL, Feb 9, 1924

20-UNDERTAKER. Zickler & Zickler — ADDRESS 1439 Eager st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83534

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N. Appleton ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Schmidt

(a) RESIDENCE NO. 714 N. Appleton ST., ... WARD 16

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schmidt

6 DATE OF BIRTH (month, day, and year) Oct 8th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Marie Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Marie A. Schmidt

(Address) 714 N. Appleton st

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5- 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec-3- 1923 to 2-5- 1924.

that I last saw h.e alive on 2-5- 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 1 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis?

(Signed) Thompson Willis, M. D.

2-5-1924 (Address) 810 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feb 8th 1924

20 UNDERTAKER: E. Schloman & Son

ADDRESS 1039 Hanover st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 001
D 83535

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Winchester ST., 15 WARD)

2-FULL NAME Robert Hutchins

(a) RESIDENCE NO. 1517 Winchester ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 75 | Months + | Days + | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: LaBor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Butt mary last

PARENTS

10 NAME OF FATHER: Jasers hutchins

11 BIRTHPLACE OF FATHER (city or town) (State or country): m d

12 MAIDEN NAME OF MOTHER: Generes Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country): m d

14 Informant: Robt Hutchins
(Address) 1517 winchester st

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to Feb 5, 1924, that I last saw h im alive on Feb 4, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(duration) 1 yrs. + mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of dead

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Charles E. Clarke, M. D.

Feb 7. 1924 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn cemetery — DATE OF BURIAL: Feb 8 1924

20 UNDERTAKER: Edward Bryan — ADDRESS 631 orleans st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83536

CERTIFICATE OF DEATH.

16-502 D 83536

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy O'Donohue.

(a) RESIDENCE No. 1513 W. Lexington ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-5-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... (illegible)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John O'Donohue

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER Mary MacDonnell

13 BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or country)

14 Informant .....
(Address) .....

15 Filed FEB 7 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 5th, 1924, to Feb 5th, 1924, that I last saw him alive on Feb 5th, 1924, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Normal delivery.

(duration) 0 yrs. 0 mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy findings

(Signed) L. M. Poltrot, M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL FEB 8 1924

20 UNDERTAKER .....

ADDRESS .....

D 83537

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 83537

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1908 Harlem Av ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ozelia A. Miles

(Residence in Baltimore: No. 1908 Harlem Av St. 45 yrs. ..... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

6-DATE OF BIRTH: May (Month) 12 (Day), 1848 (Year)

7-AGE: 75 yrs. 9 mos. 6 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ppp

9-BIRTHPLACE (State or country): Middlesex Co. Va

PARENTS

10-NAME OF FATHER: Andrew Stiff

11-BIRTHPLACE OF FATHER (State or country): Middlesex Co Va.

12-MAIDEN NAME OF MOTHER: Elizabeth Barrick

13-BIRTHPLACE OF MOTHER (State or country): Middlesex Co. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. L. Coffindaffer

(Address) 1908 Harlem Av

15- Filed FEB 7 1924 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February (Month) 6th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 10th, 1924, to, Feb. 6th 1924, that I saw h.m alive on Feb. 6th 1924, and that death occurred, on the date stated above, at 11.05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
(Not Tubercular)

unknown (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Charles L B ..... M. D.

Feb. 6th, 1924 [Address] 1111 W. Lanvale St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemy. DATE OF BURIAL: Feb 8 1924

20-UNDERTAKER: John B Spence ADDRESS: 1325 W. Carlton St

Spec.—1-10-21—M&T—1500 Bks.

D 83538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 83538

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Mens Home ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A White

(a) RESIDENCE No. 1400 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W H	Sing

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Robert White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Lalla B Fischer

(Address) 1400 W. Lexington ave

15 FEB 7 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 19 24

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 19 24, to Feb 6, 19 24, that I last saw h alive on Feb 6, 19 24 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

1 Senile Atheroma Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Woodward, M. D.

Feb 7, 19 24 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 8 1924

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 83539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83539

CERTIFICATE OF DEATH.

REGISTERED NO. 66

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2552 E. High St., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Sherwood

(a) RESIDENCE NO. 2552 E. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Police Dept, Eastern Dist
(Address)

15 Filed FEB 7 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Feb 6 192 4 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 192 FEB 7 - 192

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

34

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83540

CERTIFICATE OF DEATH.

160 D 83540

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Miller

(a) RESIDENCE No 5 N. Exeter St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Dec 30/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George Gates

11 BIRTHPLACE OF FATHER (city or town) (State or country) (Res) Bunting St

12 MAIDEN NAME OF MOTHER Bertha Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (RES) 3804 Hickory Ave

14 Informant N.E.Police Dept.
(Address)

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Odema & acute congestion of brain
Acute congestion of lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Ward, M. D. (Coroner)

Febb5/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 7 - 1924

20 UNDERTAKER (Commissioner of Health.)

ADDRESS

FEB 7 - 1924

2

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83541

CERTIFICATE OF DEATH.

X185 D 83541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. Bay View Hospital ST., No WARD)

2-FULL NAME Louis Johnson

(a) RESIDENCE No. Colon, Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	31	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deck Hand on Boat
(b) General nature of industry, business, or establishment in which employed (or employer) Elizabeth Ann
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Police Dept Eastern Dist
(Address)

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry find that said deceased came to his death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: Gangrene Left leg Following Amputation for injury to leg

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Accident - fell on Deck

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.

Feb 6th 1924 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or if death from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
JOHNS HOPKINS HOSPITAL FEB 7 - 1924	
20 UNDERTAKER	ADDRESS
Consolidated Funeral	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

21

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83542

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 83542

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. James Hosp

CITY OF BALTIMORE: (No. Charles & Center ST., 11 WARD)

2-FULL NAME Mary Winn

(a) RESIDENCE NO. Charles & Center ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER T. Winn

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Prince Gould

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs Keating
(Address)

15 Filed FEB 7 - 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to Feb. 5th, 1924, that I last saw her alive on Feb. 5th, 1924, and that death occurred, on the date stated above, at 2.25 a.m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

about 1 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Pneumonia (Lobar)
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no ~

What test confirmed diagnosis? Physical signs

(Signed) Wm F. Lockwood M. D.

, 19 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Feb 7 1924

20 UNDERTAKER Henry W Jenkins & Son — ADDRESS Preston & Eutaw Sts

Spec.—1-10-21—M&T—1500 Bks.

D 83543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 N. Charles ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Scott Bergland

(a) RESIDENCE NO. 1116 N. Charles St. ST., 11 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or ~~divorced~~
~~HUSBAND of~~
(or) ~~WIFE of~~ Eric Bergland

6 DATE OF BIRTH (month, day, and year) Feb 8. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	11.	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington - Ky.

PARENTS

10 NAME OF FATHER John McC Forland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER ~~Lucy~~ Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lexington Ky

14 Informant (Address) John McC F. Bergland - Son 1116 Biddle Street.

15 Filed FEB 7 - 1924 19.... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17 I HEREBY CERTIFY, That I attended deceased from ~~—~~ , 19 24 , to Feb 7 , 19 24.

that I last saw h alive on Feb 7 , 19 24,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C B Bramer M. D.

, 19 (Address) 2 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Feb 9 1924

20 UNDERTAKER Henry W Jenkins & Son

ADDRESS Orchard & McCollough

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

John Samuel Howard

D 83544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83544

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3124 Windsor Ave ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saml J Howard

(a) RESIDENCE. No. 3124 Windsor Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna

6 DATE OF BIRTH (month, day, and year) May 9 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Shotwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John W Howard

(Address) 3124 Windsor Ave

Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan ....., 19 24, to 2/6 ....., 19 24, that I last saw h alive on 2/4/24, 19 ....., and that death occurred, on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) (5) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy Dwelle M. D.

(Address) 1425 E Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Harmon Cem	2 1924

20 UNDERTAKER Wm Cole & Sons

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83545 HEALTH DEPARTMENT—CITY OF BALTIMORE Hull D 83545

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Laurens ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vera Annie Hyde

(a) RESIDENCE NO. 1101 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 26-1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country) N. Y.

PARENTS

10 NAME OF FATHER John Hyde

11 BIRTHPLACE OF FATHER (city or town) Norwich (State or country) Conn.

12 MAIDEN NAME OF MOTHER Susan Shepherdson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs L Hyde

(Address) 1101 Laurens.

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to Feby 6, 1924, that I last saw h alive on Feby 6, 1924, and that death occurred, on the date stated above, at 1200 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chr. myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

2/6, 1924 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Feb. 8 DATE OF BURIAL 1924 19

20 UNDERTAKER William Cook, 302 E Fayette. ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-19-21—M&T—1500 Bks.

D 83546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83546

1. PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

2-FULL NAME Lillian Venables

(a) RESIDENCE NO. 719 N. Eutaw ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: Fred Venables

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
39	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: Jim Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Hannis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 Filed FEB 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1924, to Feb 4, 1924, that I last saw her alive on Feb 4, 1924, and that death occurred, on the date stated above, at 6.35 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (Rheumatic)
Chronic Nephritis

(duration) 8 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism? Sudden death.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) R. P. Hamon, M. D.

2/5, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westwood Cem — DATE OF BURIAL: 2/8 1924

20 UNDERTAKER: Jas. Wm. Skinner — ADDRESS: 1620 E. Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 83547

HEALTH DEPARTMENT—CITY OF BALTIMORE

106-001 D 83547

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

2-FULL NAME Lillie Vanegas

(a) RESIDENCE NO. #11 W Pratt ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Frank Vanegas

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Julie Yesta

13 BIRTHPLACE OF MOTHER ~~(city or town)~~
(State or country) Lithuania

14 Informant University Hospital Records
(Address)

15 Filed FEB 7 1924 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1924 to Feb. 6 1924, that I last saw her alive on Feb. 6 1924, and that death occurred, on the date stated above, at 5 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Empyema (duration) ..... yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan. 7, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) John M. Edmunds, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb. 10, 1924
20 UNDERTAKER	ADDRESS
John L. Frederickmeyer	420 S. Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Carey

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

D 83548

CERTIFICATE OF DEATH.

74 D 83548

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Cathedral ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Carey

(a) RESIDENCE NO. 1039 Cathedral ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Carey

6 DATE OF BIRTH (month, day, and year) Nov 5-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos. Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Carey

(Address) 1039 Cathedral

15 Filed ....., 19.... ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19.... to Feb. 6th 1924

that I last saw h... alive on Feb. 6th 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Chis, M. D.

2/7, 1924 (Address) 924 Mon. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd	Feby 9th 1924
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell	W. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83549 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 83549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Portland ST., 7 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Biermann

(a) RESIDENCE NO. 704 Portland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Caroline Biermann

6 DATE OF BIRTH (month, day, and year) July 11 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dietrich Biermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Caroline Biermann

(Address) 704 Portland st

15 Filed FEB 7 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 1, 1924 to Feby 5, 1924

that I last saw him alive on Feby 5, 1924

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? - No -

What test confirmed diagnosis? Clinical

(Signed) M B Friedmann, M. D.

2/6, 1924 (Address) 632 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthias Cemy — DATE OF BURIAL Feb 8 1924

20 UNDERTAKER Fos Foerders Son — ADDRESS 2173 Pac

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ARK SEP

Cor.—1-12-23—M&T—100 Bks.

D 83550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 83550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2640 Boone ST., 20 WARD)

2-FULL NAME Wm. Thomas Downey

(a) RESIDENCE NO 2640 Boone ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Downey

6 DATE OF BIRTH (month, day, and year) Unknown 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Randolph Co. N.C.
(State or country)

PARENTS

10 NAME OF FATHER Daniel Downey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Obery

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14
Informant Mrs. R.A. ELLiott
(Address) 1725 Ashland Ave

15
FEB 7 - 1924 192
ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gangrene of both feet and legs

(Cause undetermined) (over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Bacon, M. D.
(Coroner.)

Feb 6/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Laurel Cemetery	Feb 7 192 4
20 UNDERTAKER	ADDRESS
Mrs. R.A. Elliott	1725 Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificate.

KODAK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83551 ✓

D 83551

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital WARD)

2-FULL NAME Dorthy Dowdy

(a) RESIDENCE NO. 207 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1910

7 AGE: 14 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unkn.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Unkn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Febr. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from January 19, 1923, to February 5, 1924, that I last saw her alive on Febr. 5th, 1924, and that death occurred, on the date stated above, at 1145 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Lab.

(Signed) L. A. Kelly, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery — DATE OF BURIAL: Feb. 8 1924

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 722 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83552

HEALTH DEPARTMENT—CITY OF BALTIMORE

114 D 83552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1206 Ettting St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian V. Smith

(Residence in Baltimore: No. 1206 Ettting St. St.; yrs., 2 mos. 6 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, (Month) Aug (Day) (Year) 1885

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Leander Smith

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Lois Brown

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Bertha Smith

(Address) 1206 Ettting St.

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Feb (Day) 5 (Year) 1924

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro enteritis

(Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart

(Duration) ... yrs. ... mos. 1 ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Feb. 6 1924 (Address) 280 Ed Fenderson Apt

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Norfolk Va	2-7 1924
20-UNDERTAKER George T. O. Tilton	ADDRESS 1755 Druid Hill Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83553
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

14 | 101 | 001 ✓

D 83553
Registered No. C.....

City of BALTIMORE: (No. 1623 Druid Hill Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pearl Wagner

(Residence in Baltimore: No. 1623 Druid Hill Ave. St.; yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: about (Month) (Day) 1902 (Year)

7-AGE: 21 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): N. C.

PARENTS:
10-NAME OF FATHER,
11-BIRTHPLACE OF FATHER, (State or Country),
12-MAIDEN NAME OF MOTHER,
13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Wagner

(Address) 1623 Druid Hill Ave.

15- FEB 7 - 1924 (Date Rec'd.)

ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 4 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Heiligsy M. D. (Coroner)

Feb. 6 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence North Carolina

19-PLACE OF BURIAL OR REMOVAL, Int. Auburn Cem. | DATE OF BURIAL, 2-7 1924

20-UNDERTAKER, Geo. J. A. Gibson | ADDRESS 1735 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 83554

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 829 Boyd ST., 18 WARD)

2-FULL NAME Baby Henson

(a) RESIDENCE NO. 829 Boyd ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Edward Henson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Carter

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Annie Mother Henson
(Address) 829 Boyd St

15 FEB 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924, to Feb 6, 1924, that I last saw her alive on Feb 6, 1924, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Umbilical Cord

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

2-6, 1924 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Feb 8 1924
20 UNDERTAKER	ADDRESS
Jno G Hoffman	406 N. Conway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83555

CERTIFICATE OF DEATH.

31 D 83555

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 S 3rd ST., N WARD)

2-FULL NAME Fannie L Kuemmer

(a) RESIDENCE NO. 700 S 3rd ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Kuemmer

6 DATE OF BIRTH (month, day, and year) Aug 26-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz H. Knoch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adelina Kerner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Carrie Knoch

(Address) 7055 2nd St

15 Filed FEB 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1923, to Feb 6, 1924

that I last saw her alive on Feb 6, 1924

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L Owens, M. D.

Feb 7, 1924 (Address) 35 N Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls	Feby 9 1924
20 UNDERTAKER John Ulrich	ADDRESS 20 E Eager

Spec.–12-23-21–E.B.R.S.–400 Bks.

Odie Yingling

D 83557
D 83556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 12

D 83556
D ~~83557~~

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Odie Yingling

(a) Residence No. Orla Av Elliott City Md St. Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred X yrs. X mos. 7 ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Yingling

6-DATE OF BIRTH (month, day and year) Dec. 5, 1897

7-AGE. 26 yrs. 2 mos. # ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ballo

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic Duties

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) Do not know (State or Country)

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) Do not know (State or Country)

11-(Informant) Chas. Yingling

(Address) Orla Ave Elliott City Md

FEB 7 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 29 19 23 to Feb. 5 19 24

that I last saw her alive on Feb. 5 19 24

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis c Peritonitis

(Duration) yrs. mos. 3 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-2-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Goldenberg, M. D.

19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL/CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL. Feb. 8 19 24

20-UNDERTAKER. By Easton Sons ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

83557
D 83557

HEALTH DEPARTMENT—CITY OF BALTIMORE

83557
D 83557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 N Woodyear St.: 19 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Quinn

(a) RESIDENCE. No. 324 N Woodyear St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Hugh Toose

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gable

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr Inman
(Address) 324 N Woodyear St

15 Filed ..... 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

FEB 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 — 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 ..... 19 23 to Feb 6 ..... 19 24,
that I last saw h.. alive on Feb 5 ..... 19 24,
and that death occurred, on the date stated above, at 11-40 a.m.
The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. H. Wirtz, M. D.

Feb 7 19 (Address) 1302 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 9 19
20 UNDERTAKER John J Fritz	ADDRESS 1210 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

D. 83558 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 83558

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 713 E. Chase St. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Shea

(a) RESIDENCE NO. 713 E. Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept., 14-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	35	4	21	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James W. Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie McDermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Mollie McDermott Shea.

(Address) 713 E. Chase St.

15 Filed FEB 7 1924, 19 Robert F. Murphy Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb., 5 19 24

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 23, to Feb 5, 19 24,

that I last saw him alive on " 4, 19 24,

and that death occurred, on the date stated above, at 3.50 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Coolidge, M. D.

2/5, 1924 (Address) 24 N. Bulting Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL 2/8/24 19

20 UNDERTAKER C.F. Evans & Son; 118 W. Mt Royal Ave.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83559

CERTIFICATE OF DEATH.

X 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere Hotel ST., 11 WARD)

2-FULL NAME Gilbert K. Pollock, Sr.

(a) RESIDENCE NO. 215 N. Boulevard Richmond Va ST., WARD Richmond Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ferdie Pollock

6 DATE OF BIRTH (month, day, and year) May 4-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Mrs Ferdie Pollock (Address) 215 N. Boulevard - Richmond

15 Filed 19 Robert P. Harrison, Va. Registrar

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924, to Feb. 7, 1924

that I last saw h[illegible] alive on Feb. 7, 1924

and that death occurred, on the date stated above, at 9:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis L. Kearney M. D.

, 19 (Address) 16 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond, Va

DATE OF BURIAL 2/7 1924

20 UNDERTAKER Henry W. Dreaus & Son

ADDRESS 805 N. Gilmore St.

Spec.—1-10-21—M&T—1500 Bks.

D 83560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83560

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2741 W North Ave ST. 15 WARD)

2-FULL NAME Mary Smith

(a) RESIDENCE NO. 2741 W North Ave ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos J Smith

6 DATE OF BIRTH (month, day, and year) Aug 8 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs ..... (Address) 2741 W North Ave

15 FEB 7 - 1924 Robert P. Harrison, ..., 19 ..... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Feb 5, 1924, that I last saw h.. alive on Feb 5, 1924, and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

1 Chronic Myocarditis.

2 Acute nephritis 2

3 H B P. Senile arteriosclerosis

..... (duration) ..... yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma 2

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H Stanley Hillman M. D.

Feb 7, 1924 (Address) 1 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 2/8 1924

20 UNDERTAKER Geo A Finley ADDRESS Fulton & Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83561

CERTIFICATE OF DEATH.

Hillcrest Mt Wash, D 83561

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Stewart & Linwood ST., 27 WARD)

2-FULL NAME Absalom S. Boley

(a) RESIDENCE No. Stewart & Linwood Ave ST., WARD Hyattsville Md

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lilly B Boley

6 DATE OF BIRTH (month, day, and year): May 29 1854

7 AGE — Years: 69 Months: 8 Days: 8 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Garret Boley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Lilly B Boley

(Address): Stewart & Linwood Ave

15 FILED FEB 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Jan 7, 1924, that I last saw him alive on Jan 7, 1924, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder (suspected) over

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) none known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic

(Signed) S Stewart M. D.

(Address) 805-10-38 Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville

DATE OF BURIAL: Feb 8 1924

20 UNDERTAKER: H S Marshall

ADDRESS: 3539 Fall Road

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Zimmerman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83562

CERTIFICATE OF DEATH.

D 83562

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 N Fenton ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Zimmerman

(a) RESIDENCE. No. 1905 N Fenton ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Mulr	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theo Zimmerman

6 DATE OF BIRTH (month, day, and year) Jan 31, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jacob Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Fred Zimmerman 1905 N Fenton

Filed FEB 7 - 1924 Robert F. Harris..., Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Feb 5, 1924.

that I last saw h alive on Feb 5, 1924.

and that death occurred, on the date stated above, at 1045 a. m.

The CAUSE OF DEATH* was as follows:

Rt Hemiplegia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

2/6, 1924 (Address) 2027 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb. 8 1924
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fallard

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S [illegible] state may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be supplied. AGE should be

Spec.—1-10-21—M&T—1500 Bks.

D 83563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Bank ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislawa Damesyn

(a) RESIDENCE No. 1812 Bank ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Frank F. Damesyn

6 DATE OF BIRTH (month, day, and year) Apr. 12, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Mikolaj Jawinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rogalia Gorka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank F. Damesyn

(Address) 1812 Bank St.

15 Filed ....., 19.... Robert T. Morfield, Registrar

Burial Permit Clerk.

F 187 -1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 25 ~~Feb~~ 1924 to Feb 7 1924, that I last saw h[illegible] alive on Feb 6 1924, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchs. pneumonia

8

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Keller, M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL 2/11/1924

20 UNDERTAKER Wm. Fialkowski — ADDRESS 1618 Eastern

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83564

CERTIFICATE OF DEATH.

D 83564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Fleet ST., 1 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antoni Fialkowski

(a) RESIDENCE No. 2314 Fleet ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/5/1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Antoni Fialkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Mazorek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Antoni Fialkowski

(Address) 2314 Fleet St

15 FEB 7 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924, to Feb 7 1924,

that I last saw him alive on Feb 6, 1924,

and that death occurred, on the date stated above, at 11-4 m.

The CAUSE OF DEATH* was as follows:

Pneumonia -

Lobar - right - upper

Contributory Delirium Tremens

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M.D. M. D.

, 192 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	2/8/1924
20 UNDERTAKER	ADDRESS
Wm. Fialkowski	1618 Eastern

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16942 H

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83565

90 D 83565

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL 15

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.....ST.,.....WARD)

2-FULL NAME John Duggan

(a) RESIDENCE NO. 3704 Park Heights Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. B. Duggan

6 DATE OF BIRTH (month, day, and year) May 5 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~Ed~~	49	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk odd

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Retired

9 BIRTHPLACE (city or town) ~~Ireland~~ Portsmouth, Va

(State or country)

PARENTS

10 NAME OF FATHER Patrick Duggan

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Ella McMenamin

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant (Address) Record JOHNS HOPKINS HOSPITAL

15 Filed ....., 19..... Robert J. ....

Registrar

Burial Permit Clerk.

FEB 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Feb 5, 1924, that I last saw h.. alive on Feb 5, 1924, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Feb 8 1924

20 UNDERTAKER Wm. J. Ricker & Sons

ADDRESS Norfolk Va

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every letter of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83566

CERTIFICATE OF DEATH.

D 83566

1-PLACE OF DEATH

City of BALTIMORE: (No. 2125 Bolton St., 13 Ward)

Registered No. 90

2-FULL NAME Charles C. Holbein

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2125 Bolton st. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth L. Holbein

6-DATE OF BIRTH (month, day and year) Mar. 14 1853

7-AGE, 70 yrs. 10 mns. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ship Inspector

(b) General nature of Industry, business, or establishment in which employed (or employer): Retired 086

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto.

PARENTS.

10-NAME OF FATHER. John Holbein

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Holland

12-MAIDEN NAME OF MOTHER. Julia Corbett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto.

14- (Informant) Mrs Elizabeth L. Holbein

(Address) 2125 Bolton St.

15- FEB 7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 7. 24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 5 1924 to Feb. 6 1924, that I last saw h—alive on Feb. 6 at 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

mitral regurgitation & insuff.

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) arterio sclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? heart sounds.

(Signed) H. J. Steinbach Jr. M. D

, 19 (Address) 631 Cathedral.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 9, 1924
20-UNDERTAKER	ADDRESS
Wm Fletcher Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83567

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83567

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3704 Park Heights Ave (St.) 5 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Simpkins

(a) Residence No. 3704 Park Heights Ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary Simpkins

6-DATE OF BIRTH (month, day and year): Oct 5 1844

7-AGE: 79 yrs. 4 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): N. J.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant): Mrs. J. F. Duggan

(Address): 3704 Park Heights Ave.

15- Filed FEB 7 - 1924 192.... Albert S. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb. 6 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19 22 to Feb. 6 19 24

that I last saw h.. alive on Feb. 6 19 24

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation (myocarditis

(Duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dorsey M. Sittle M. D

2/7, 1924 (Address) 1 E 35 Mary Cambridge

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem't | DATE OF BURIAL: FEB 8. 1924

20-UNDERTAKER: W. J. Pickerson Sons | ADDRESS: Norfolk Va

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83568

161-001 D 83568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 S. First ST., 26 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman B. Kohlhoff Jr.

(a) RESIDENCE No. 801 S. First ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 17, 1924

7 AGE — Years: — Months: — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Herman B. Kohlhoff Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Regina Fegiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Herman Kohlhoff 801 S. First St.

15 Filed ..... Robert F. Harrison, Registrar

EB 7 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 12" 1924 to Feb 6th 1924.

that I last saw him alive on Feb 6th 1924

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

8 Month baby Premature

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary): Marasmus

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? X

Did operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) ..... M. D.

, 19 (Address) 1340 S Charles.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Feb. 8 1924

20 UNDERTAKER: Margaret S. Flynn — ADDRESS: 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83569

CERTIFICATE OF DEATH.

× 31 ✓ D 83569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST., WARD)

2-FULL NAME John Mason

(a) RESIDENCE NO. 851 North side, Sparrows Point ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steel worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Henry mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Ellen Langdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: Hospital Records

(Address): M. T. H.

15 Filed FEB 8 - 1924, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1923, to Feb. 5, 1924, that I last saw him alive on Feb. 5, 1924, and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary): Tuberculous pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally M. D.

2-5-24, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pinnacle N. C.

DATE OF BURIAL: Feb 8 1924

20 UNDERTAKER: Sam'l W. Edwards Son

ADDRESS: 400 Mosher

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83570

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 N. Streeper St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Gilliam

(a) Residence No. 618 N. Streeper St., 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: David E. Gilliam

6-DATE OF BIRTH (month, day and year): June 18th 1874

7-AGE: 49 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: Wm H. Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Mary L. Reynolds

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md

14- (Informant): David E. Gilliam

(Address): 618 N. Streeper St.

Filed FEB 8 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb. 6th 1924.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 4 1924 to Feb 6 1924

that I last saw her, alive on Feb 6 1924

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? By Operation

(Signed) Jas E Bullis M. D

18 (Address) 1432 E. Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery

DATE OF BURIAL: Feb. 9 1924

20-UNDERTAKER: Lilly & Zuller

ADDRESS: 400 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83571 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 83571

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 113 White Avenue (Hamilton) 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Christian Julius Smith

(Residence in Baltimore: No. 113 White Avenue (Hamilton) St.; yrs., Life mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. December 24 (Month) (Day) 1901 (Year)

7-AGE. 22 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Discount clerk
(b) General nature of Industry, business, or establishment in which employed (or employer): at Bank 009

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Andrew E. Smith

11-BIRTHPLACE OF FATHER. (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Barbara Hebrank

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew E. Smith

(Address) 113 White Ave. Hamilton

FEB 8 - 1924 (Date) ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 6 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to hfg death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation - hanging by neck-
Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

2-6 1924 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine Cem.	Feb 9 1924
20-UNDERTAKER.	ADDRESS
Jos. L. Cook	100 3d Balto St

D 83572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83572

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

19 181

Registered No. C.....

City of BALTIMORE: (No. 355 S. Woodyear St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Brown Hill

(Residence in Baltimore: No. 355 S. Woodyear St. St.; yrs. life mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, November 29 (Month) 873 (Day) (Year)

7-AGE.	If LESS than 1 day,
50 yrs. 2 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) B & O Railroad

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas J. Hill

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary E. Reed

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel W. Hill

(Address) 1312 Linden Ave.

FEB 8 - 1924 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 7 (Month) (Day) 4 (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Poisoning Accidental

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Inquest

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo. E. Reed M. D. (Coroner.)

2-7 1924 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Feb 9 1924

20-UNDERTAKER.	ADDRESS
Wm B Cook	1003 W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83573

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 83573

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 319 Roland Ave. St., 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Gibson Kleinle

(a) Residence No. 319 Roland Ave, St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. -- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William Kleinle

6-DATE OF BIRTH (month, day and year) ----------

7-AGE. 72 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pocomoke, Md.

PARENTS.

10-NAME OF FATHER, Joseph Adreon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Winifred Cooper

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Mrs. R. Brooke Maxwell

(Address) 319 Roland Ave

15- FEB 8 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 6 1924

17- I HEREBY CERTIFY, That I attended deceased from 1920, 19.. to Feb. 6, 19 24

that I last saw h.. alive on Feb 4 19 24

and that death occurred, on the date stated above, at 330 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Myxoedema

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Nancy S Beck M. D.

, 19 (Address) 202 Cambridge Ln.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	2/8/24 19
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83574

CERTIFICATE OF DEATH.

101-001

Registered No. D-83574

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Monaghan

(a) Residence No. St. Agnes Hospital St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Jan 28, 1866

7-AGE, 58 yrs. 0 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Orderly 080

(b) General nature of industry, business, or establishment in which employed (or employer) St. Agnes Hospital

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Patrick Monaghan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ellen Monaghan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) Ella Monaghan

(Address) East Coyt

Filed FEB 8 - 1924 192 Ft. Paul & Pratt

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 28 1924 to Feb. 7 1924

that I last saw him alive on Feb. 4 1924

and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) S. Goldeman M. D

19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Feb. 8 A. 1924
20-UNDERTAKER.	ADDRESS
Elmer W. Conklin	1245 E Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83575

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

REGISTERED NO. 1924 D 83575

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Lang

(a) RESIDENCE No. 920 Greenmount Ave ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X Child

6 DATE OF BIRTH (month, day, and year) Nov 7 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Lang

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Agnes Linz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed FEB 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Feb 6, 1924, that I last saw h.. alive on Feb 6, 1924, and that death occurred, on the date stated above, at 11 1/2 P m.

The CAUSE OF DEATH* was as follows: Hydrocephalus (purulent)

abt

(duration) yrs. 1 mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas J Bagg M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feb 8, 1924

20 UNDERTAKER Elmer W. Coulbourn — ADDRESS 924 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83576 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 D 83576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1536 W. Lexington St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Cobb

(a) Residence No. 1536 W Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State) Virginia

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Cobb

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Sarah Baker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-

(Informant) John Cobb

(Address) 1536 W Lexington St.

FEB 8 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to Feb 7, 1924, that I last saw h.. alive on Feb 6, 1924, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

7 days (Duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Tobacco

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Edward Fisher M. D.

2-7, 1924 (Address) 1612 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Prospect Va — DATE OF BURIAL. Feb. 8 1924

20-UNDERTAKER. A. Jones — ADDRESS, 11 S. Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83577

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83577

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1069 W Lexington ST., 18 WARD)

2-FULL NAME Julius W. Jones

(a) RESIDENCE NO. 1069 W Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Julia R. Jones

6 DATE OF BIRTH (month, day, and year): June 1878

7 AGE — Years: 45 Months: 8 Days: 6 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer): 07

(c) Name of employer: Mutual Benefit Ins Co Balto Md

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Edward Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Julia R. Jones 1069 W Lexington St

15 FEB 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 24 1924 to Feby 6, 1924, that I last saw h[e] alive on Feby 6, 1924, and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Acute Cholecystitis as Complication (duration) mos 18 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. F. Hovilt M. D.

2/8, 1924 (Address) 119 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL 2/9 1924

UNDERTAKER: Samuel H Kunsley ADDRESS 1128 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state so, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83578

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Carrol Poultney.

(a) RESIDENCE No. 603 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Male	White	Single

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	72	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thos. Poultney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Milliken

(Address) 603 N. Charles St

15 Date FEB 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/1924

17

I HEREBY CERTIFY, That I attended deceased from Jan'y 30th, 1924, to Feb. 6th, 1924.

that I last saw him alive on Feb 6th, 19...

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Had Cerebral hemorrhage, with partial Hemiplegia several years ago)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Acute Dilatation)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. S. Love M. D.

, 19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 2-9 1924

20 UNDERTAKER Henry W. Jenkins & Sons Co

ADDRESS Mitchell & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 83579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 83579

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3727 North Road Wallbrook ST.: 15 WARD)

2-FULL NAME Milton Dunkard

(a) RESIDENCE. No. 3727 North Road ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6 / 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frederick E Dunkard

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Florence Henry

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Frederick E Dunkard
(Address) 3727 North Road

15 FEB 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924, to Feb 6, 1924, that I last saw h[im] alive on Feb 6, 1924, and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
7½ Mos Gest

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Stifler, M. D.

2/7, 1924 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 8th 1924
UNDERTAKER E Schloman & Son	ADDRESS 1039 Hanover st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83580

CERTIFICATE OF DEATH.

D 83580

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E. Monument ST., 7 WARD)

2-FULL NAME Susan Campbell

(a) RESIDENCE NO. 1511 E Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M.

5a If married, widowed, or divorced (~~Husband of~~ or) WIFE of William Campbell

6 DATE OF BIRTH (month, day, and year) 1868?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Peter Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown 2/7

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Robert A Elliott (undertaker) (Address)

15 FEB 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept ..., 1923 ..., to Feb 6 ..., 1924.
that I last saw he alive on Feb 4 ..., 1924
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(duration) 6 yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Chronic Bronchitis
(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? no Date of ...
Was there an autopsy? no
What test confirmed diagnosis? Physical & Lab
(Signed) R Y ..., M. D.
, 1924 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Feb. 10 1924

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1726 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83581 83581

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 247 N. Schroeder St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mass Blaeson

(Residence in Baltimore: No. 247 N Schroeder St. St; yrs., 69 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, ... 1854
(Month) (Day) (Year)

7-AGE, 69 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 041
(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Moses Brown

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Jessie Brown

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Bates

(Address) 247 N Schroeder St

15. FEB 8 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb 6, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

2-7 ..... 1924 (Address) .....

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn Cem	Feb 9, 1924
20-UNDERTAKER,	ADDRESS
Brauer & Eckhardt	114 N Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83582

D 83582

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 941 Sarah ann St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Jennie Johnson

(Residence in Baltimore: No. 941 Sarah ann st St.; yrs., 46 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	Widow

6-DATE OF BIRTH.

....., 1877
(Month) (Day) (Year)

7-AGE. If LESS than 1 day, ...hrs. or....min.?

46 yrs. mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. William Evans

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Jennie Evans

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Johnson

(Address) 941 Sarah ann St

15- FEB 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 6 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe bronchial pneumonia

Contributory Influenza

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

192.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	Feb 8 1924

20-UNDERTAKER.	ADDRESS
Bromwell Funeral Home	114 W Lexington St

Cor.—1-12-23—M&T—100 Blks.

D 83583

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 N. Calvert ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Flaherty (or Mrs. Francis Scully)

(a) RESIDENCE NO. 806 N. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married & Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Scully & Suit

6 DATE OF BIRTH (month, day, and year) Dec 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Co. a Police Dept (Address)

15 Medical Certificate received FEB 8 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1924
Found dead Feb. 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest and autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and autopsy find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Kelly, M. D.
(Coroner.)
Feb 6 1924 (Address) 1629 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 5 mos.
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence ?

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/8/1924

20 UNDERTAKER E. J. Canning & Son 1938 E. Lafayette ave ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83584

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 415 S 14th St. 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise B Happ

(a) Residence No. 415 S 14th St., Ward Germania W. 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Happ

6-DATE OF BIRTH (month, day and year) Oct 3d. 867

7-AGE. 56 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), W Va

PARENTS.

10-NAME OF FATHER, — Rowe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), W Va

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Mrs J G Lemley

(Address) Bridgeport W Va

15-

FEB 8 - 1924

ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/7/1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1924 to Feb 7 1924

that I last saw h.. alive on Feb 7 1924

and that death occurred, on the date stated above, at 8 00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy & Uraemia

(Duration) 1 yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. J. Murr M. D.

28 , 1924 (Address) 811 E Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Fairmount W Va — DATE OF BURIAL, Feby 8, 1924

20-UNDERTAKER, John Ullrich — ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U.S.A. COPY

Spec.—1-10-21—M&T—1500 Bks.

D 83585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83585

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Presbury ST., 15 WARD)

2-FULL NAME Mrs Frederick Gell.

(a) RESIDENCE NO. 1717 Presbury ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., If of foreign birth? Lifetime ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher J. Gell.

6 DATE OF BIRTH (month, day, and year) Sept 23/55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Hump.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Wilhelmina Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George C. Shannon (Address) 700 Fulton Ave

15 ROBERT R. KRAUTER, Registrar

FEB 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 1923 to Febry 6 1924, that I last saw her alive on Febry 4 1924, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. one mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon, M. D.

2/7, 1924 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Southedal Cem	Feb 9 1924

20 UNDERTAKER Martin Haley & Son ADDRESS 1717 W North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83586

CERTIFICATE OF DEATH.

164 D 83586

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4906 York Road ST., 7 WARD)

2-FULL NAME William Henry Harvey

(a) RESIDENCE NO. 4906 York Road ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma J.Harvey

6 DATE OF BIRTH (month, day, and year) April 7 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Canmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Desdemona McKinley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Emma J.Harvey

(Address) 4906 York Road

FEB 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15. 1924. to Feb 7. 1924.

that I last saw h live on Feb 6. 1924.

and that death occurred, on the date stated above, at 8.10 A.M.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Ophthalmia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. E. Campbell, M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Feb 11 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 83587

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83587

CERTIFICATE OF DEATH.

90 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2758 Fenwick Ave S., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Henry Lomax

(a) Residence No. 2758 Fenwick Ave S., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Almira E Lomax

6-DATE OF BIRTH (month, day and year) Dec 25 1850

7-AGE. 73 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), St Mary Co Maryland

PARENTS.

10-NAME OF FATHER Richard Lomax

11-BIRTHPLACE OF FATHER (city or town) (State or Country), St Mary Co Maryland

12-MAIDEN NAME OF MOTHER Maria Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Miss Mary E. Lomax

(Address) 2758 Fenwick Ave

15- FEB 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan, 19.2 to Feb 7, 19.24

that I last saw him alive on Feb 7 19.24

and that death occurred, on the date stated above, at 5.55 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Arteriosclerosis heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

2 (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. E. Zimmermann M.D.

2/7, 1924 (Address) 2358 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	Feb 9, 1924
20-UNDERTAKER, John F Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every Answer should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Killian Herold

83588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 83588

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N Modena ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Killian Herold

(a) RESIDENCE NO. 408 N Modena ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaretha Herold.

6 DATE OF BIRTH (month, day, and year) Dec 15 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	69.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) German

PARENTS

10 NAME OF FATHER John Herold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa Herold

(Address) 402 E Fairmount St

15 FEB 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1923 to Feb 7, 1924

that I last saw him alive on Feb 7, 1924

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Rysavek, M. D.

(Address) 892 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Post Holy Redeemer — DATE OF BURIAL Feb. 1924

20 UNDERTAKER Wendell Hoppe & Son — ADDRESS 372 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83589

CERTIFICATE OF DEATH.

38 D 83589

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1803 Aliceann ST., 12 WARD)

2-FULL NAME John L Milanicz

(a) RESIDENCE No. 4000 Fullerton ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine F Milanicz

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1888

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Milanicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Glenski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Catherine F Milanicz
(Address) 4000 Fullerton Rd.

FEB 8 - 1924

ROBERT R. KRAUSER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1923 to Feb 7 1924

that I last saw h.. alive on Feb 6 1924

and that death occurred, on the date stated above, at 5A. m.

The CAUSE OF DEATH* was as follows:

Cerebro - Spinal Lues

Unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypo Stasis Congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) William Dooley M. D.

, 19 (Address) 3821 Dillwyn Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Feby 11 - 1924.

20 UNDERTAKER W. J. Sadowski.

ADDRESS 905 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Catherine M. Curley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83590

CERTIFICATE OF DEATH

90 D 83590

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME Catherine M. Curley

(a) RESIDENCE NO. 1506 Paul ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	about 78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Bernard Curley

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Mathilda Gold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant: Taylor Brooks

(Address) 1506 Carlton Ave

FEB 8 Filed 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-8, 1924, 19 to 2, 8, 1924.

that I last saw her alive on 2, 8, 1924, 19

and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

pneumonia thrombosis

myocardial insufficiency

auricular fibrillation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) R. Tyler, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 9 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Co	Orchard & Fulton

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83591

CERTIFICATE OF DEATH.

5 31

D 83591

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Rose

(a) RESIDENCE No. 250 N. Exeter st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1869

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Andrew Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 8 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1923 to Feb. 4, 1924,

that I last saw him alive on Feb. 4, 1924,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) L. A. Lally, M. D.

2-4-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 8 - 1924

20 UNDERTAKER Commissioner Health.

Per Wm. E. WOODALL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83592

CERTIFICATE OF DEATH.

74-20

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3344 E. Baltimore ST., 76 WARD)

2-FULL NAME Charles H. Drury

(a) RESIDENCE No. 3344 E. Baltimore ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie R. Drury

6 DATE OF BIRTH (month, day, and year) Sept. 9-1865

7 AGE — Years: 58 — Months: 4 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): Penn. R.R Co.

(c) Name of employer: Ind. City

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. H. Drury

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Keys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Annie R. Drury
(Address) 3344 E. Baltimore

15 Filed FEB 8 -1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to Feb 5, 1924, that I last saw him alive on Feb 5, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Consultation

(Signed) Geo Clinton Bladen M. D.

(Address) 1437 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: 2/9/1924

20 UNDERTAKER: J. J. Moran

ADDRESS 3006 E. Baltimore

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be stated so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83593

CERTIFICATE OF DEATH.

X151 D 83593

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Henry Warfield

(a) RESIDENCE NO. Perryman Md. WARD Perrymans Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer O&b

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Warfield

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Susan Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital Record. (Address)

15 Filed FEB 8 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7/24. 19

17 I HEREBY CERTIFY, That I attended deceased from 1/29/24, 19..... to 2/7/24, 19.....

that I last saw him alive on 2/7/24, 19.....

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene of Left Leg.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 2/1/24.

Was there an autopsy? No

What test confirmed diagnosis? Clinical Features

(Signed) K. W. Kelley, M. D.

19 (Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md. DATE OF BURIAL 2/8 1924

20 UNDERTAKER Wm J. Tuckner & Sons ADDRESS North Penna. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every line mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83594

CERTIFICATE OF DEATH.

D 83594

1-PLACE OF DEATH /

CITY OF BALTIMORE: (No. 1016 S. Paca ST., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J McCaffrey

(a) RESIDENCE NO. 1016 S. Paca ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31 -	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Paul J. McCaffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dora Bassett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hilda McCaffrey

(Address) 1016 S. Paca St

FEB 8 - 1924 Filed ....., 19 ..... Robert P. Hartlich, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924, to Feb 7, 1924; that I last saw h[illegible] alive on Feb 7, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ..... yrs. one mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) J. M. Tompkins, M. D.

Feb 8 1924 (Address) 426 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 11 1924
20 UNDERTAKER James Dignan & Son	ADDRESS 1003 E. Fayette St

CAUSE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83595

CERTIFICATE OF DEATH.

D 83595

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

2-FULL NAME Mrs John D Silk. (Etta May Silk)

(a) RESIDENCE NO. 922 Sunnyside Ave ST., WARD Chicago, Ill.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? 46 yrs. 4 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr John D Silk

6 DATE OF BIRTH (month, day, and year) Sept-11-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Indiana
(State or country) U.S.A.

PARENTS

10 NAME OF FATHER George P. Wood (dec)

11 BIRTHPLACE OF FATHER (city or town) Ohio
(State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Mary E Hine

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 Informant John D Silk - (husband)
(Address) Chicago - Ill.

Filed FEB 8 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924, to Feb 7, 1924,

that I last saw her alive on Feb 7, 1924,

and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the small intestine
Perforation of the bowel with
Peritonitis following

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 922 Sunnyside ave, Chicago

Did an operation precede death? yes Date of Feb 7, 1924

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Raymond I. Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kokomo - Indiana — DATE OF BURIAL Feb 8 1924

20 UNDERTAKER THE J. E. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 100 W. MONUMENT

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular that CAUSE OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83596

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Schultz

(a) Residence No. 1362 Columbia Ave St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1885 Year 22

7-AGE, 39 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Safe Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 08

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John Schultz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER, Maggie Henly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Palto., Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

FEB 8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 21, 1924 to February 7 1924 that I last saw him alive on February 7, 1924 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Tongue,
General Metastasis

(Duration) yrs. 6 mos. ds

CONTRIBUTORY (Secondary) --

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D

2-8-, 1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Feb. 11, 1924
20-UNDERTAKER, George J. Smith	ADDRESS 1532 Hollins

INSTRUCTIONS—Certificate should be carefully prepared. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83597

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-005

D 83597

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2701 Guilford ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert M. Lovell

(Residence in Baltimore: No. 2701 Guilford ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Nov (Month) 3 (Day) 1874 (Year)

7-AGE: 49 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer): Own business

9-BIRTHPLACE, (State or Country): Balt md

PARENTS.

10-NAME OF FATHER, James Lovell

11-BIRTHPLACE OF FATHER, (State or Country), Ire.

12-MAIDEN NAME OF MOTHER, Ann Kreger

13-BIRTHPLACE OF MOTHER, (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Forgett Lovell

(Address) 2701 Guilford ave

15-

Filed FEB 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb (Month) 6 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Gas.
Accidental

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Robt M Harrison M. D. (Coroner.)

Feb 7 1924 (Address) 3632 Rolandave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL, Feb. 9 1924

20-UNDERTAKER, H. Sander Sons ADDRESS 1710 Park Ave

FEB. —Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 83598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83598

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 W Lexington ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Frenie

(a) RESIDENCE No. 813 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Louis Frenie

6 DATE OF BIRTH (month, day, and year) October 1, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo W Schmeltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Frenie

(Address) 813 W Lexington St

15 Filed FEB 8 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 5 - 1924, 19

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Feb 6, 1924, that I last saw her alive on Feb 6, 1924, and that death occurred, on the date stated above, at 11-50 A m.

The CAUSE OF DEATH* was as follows:

Recurring Cerebral Hemmorrhage

(duration) ✓ yrs. ✓ mos. 14 ds.

CONTRIBUTORY (Secondary) Senile Arterio sclerosis

(duration) yrs. 6 wks. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Henry C Thelen M.D.

FEB 5 - 1924, 19 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park

DATE OF BURIAL FEB 8 - 1924, 19

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 83599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Poplar Grove ST., 16 WARD)

2-FULL NAME Mary Jane Greene

(a) RESIDENCE No. 1100 Poplar Grove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: John Greene

6 DATE OF BIRTH (month, day, and year): June 13, 1840

7 AGE — Years: 80 — Months: 7 — Days: 25 — If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone yd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Andrew Lee

(Address): 1100 Poplar Grove St

15 Filed FEB 8 - 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): FEB 6 - 1924, 19..

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1923, to Feb 8, 1924, that I last saw her alive on Dec 8, 1924, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

1 Hemorrhage of Bowels

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Richardson M. D.

, 19 (Address) 1100 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: FEB 9 - 1924, 19..

20 UNDERTAKER: Geo W. Little

ADDRESS 2400 EDMONDSON AVE.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question should be answered. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83600

CERTIFICATE OF DEATH.

31 D 83600

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Millington Av ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Rosenberger

(Residence in Baltimore: No. 513 Millington Ave St.; 36 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov (Month) 7 (Day) 1857 (Year)

7-AGE, 66 yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Terra Cotta Worker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Alsace Lorraine Germany, France

PARENTS.

10-NAME OF FATHER, George Rosenberger

11-BIRTHPLACE OF FATHER (State or Country), France

12-MAIDEN NAME OF MOTHER Katrine Mick

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Rosenberger

(Address) 513 Millington Ave

15-

Filed ..... 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 8th (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 1923, to Febr. 8 1924, that I saw him alive on Febr 7th 1924, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines
(Chronic Pleurisy)

(Duration) 1 yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Joseph E. Gichner M. D.

Febr 8, 1924 (Address) 516 Madison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. New Cathedral DATE OF BURIAL. Feby 11, 1924

20-UNDERTAKER. Little Johnson Inc ADDRESS 4 E Pray

38 - 1924

Spec.—1-10-21—M&T—1500 Bks.

D 83601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83601

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 N. Broadway ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie A. Slemmer

(a) RESIDENCE NO. 1232 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If ~~married, widowed, or divorced~~ ~~(HUSBAND) of~~ (or) WIFE of: Milton C. Slemmer

6 DATE OF BIRTH (month, day, and year): ? ? 1854

7 AGE: 69 (Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None (37)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Enoch Moreland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D C

12 MAIDEN NAME OF MOTHER: ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D C

14 Informant: Milton Slemmer

(Address): 1232 N Broadway

15 Filed FEB 8 - 1924, 19 ..... Robert F. Harrison, Registrar

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1924

17

I HEREBY CERTIFY, That I attended deceased from January 10, 1924, to Feb 6, 1924, that I last saw her alive on Feb 5, 1924, and that death occurred, on the date stated above, at 1:45 A m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): fibroid tumor uteri

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

2/7/24. (Signed) Fritz J Kinzer, M. D.

19 (Address) 2700 Hartford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Feb 9 1924

20 UNDERTAKER: Robt J Turner Jr — ADDRESS: 1442 W Broadway

INK—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83602

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Warwick Ave St. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jane Bull

(a) RESIDENCE. No. 1636 Warwick Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emmanuel Bull

6 DATE OF BIRTH (month, day, and year): January 14, 1835

7 AGE: Years 89 | Months 0 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan Mdeuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Bull, (Address) 1636 Warwick Avenue

15 Filed FEB 8 1924, 19 Robert F. Harrison, Registrar [Burial Permit Clerk.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1924, to Feb. 6, 1924, that I last saw h[illegible] alive on Feb. 6, 1924, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/7/24 (Address) 2737 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westview Cemetery Balto. Co. Md.

DATE OF BURIAL: February 9, 1924

20 UNDERTAKER: E. LeRoy Stuffler

ADDRESS: 125 E. North Ave

WRITE PLAINLY, WITH PENDING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83603

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83603

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1337 N. Gilmor ST. 15 WARD)

2-FULL NAME John Samuel Jones

(a) RESIDENCE NO. 1337 N. Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 7th 1923

7 AGE: Years — Months 3 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Bessie Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Jones
(Address) 1337 N. Gilmor

15 FEB 8 - 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1924, to Feb 7th, 1924, that I last saw him alive on Feb 5th, 1924 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Surgical

(Signed) Harry P. Brown M. D.

Feb 7th 1924 (Address) 501 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL Feb 9 1924

20 UNDERTAKER: Samuel E. Wright — ADDRESS 1364 W. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83604

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2902 Garrison Blvd ST., 15 WARD)

2-FULL NAME James Harvey Stone

(a) RESIDENCE NO. 2902 Garrison Blvd ST., 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie T. Stone

6 DATE OF BIRTH (month, day, and year) Oct 30 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice - President

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Casualty Co

(c) Name of employer Same.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Harvey Stone

11 BIRTHPLACE OF FATHER (city or town) Mass (State or country)

12 MAIDEN NAME OF MOTHER Harriet Frankland

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs James H Stone

(Address) 2902 Garrison Av

15 FEB 8 - 1924 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 1920, to Feb 7 1924,

that I last saw him alive on Feb 6 1924,

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Marshall B Wright, M. D.

Feb 9 1924 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Feb 9 1924

20 UNDERTAKER: H. Allen Fuller — ADDRESS: 2902 Garrison Blvd

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83605

CERTIFICATE OF DEATH.

100-001 ✓ D 83605

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 St. Mary ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John St Jefferson

(a) RESIDENCE NO. 415 St Mary ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 65 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
~~(or) WIFE of~~ HUSBAND of Susan Jefferson

6 DATE OF BIRTH (month, day, and year) Oct 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co
(State or country) Md

PARENTS

10 NAME OF FATHER David Jefferson

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Maggie A. Evans

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Md

14 Informant Clara Johns
(Address) Mechanicsville Md.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
FEB 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15 1923 to Feb 7 1924
that I last saw h.. alive on Feb 7 1924
and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) Cellus Sclerosis of Lungs (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr Lee Ellis, M. D.

2/8, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 2/9 1924

20 UNDERTAKER Samuel I. Newsley W. Biddle. ADDRESS 928

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation in plain terms, so that it may be properly classified. Exact statement of ... CAUSE OF DEATH ... TION is very important. See instructions on back of certificate. ... UPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83606

101-00

D 83606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 E White ave ST. Hamilton WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Lawrence Riefner Jr.

(a) RESIDENCE No. 40 E. White ave ST., Hamilton WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltd. Maryland.

PARENTS

10 NAME OF FATHER Henry L. Riefner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Marie E. Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Henry L. Riefner

(Address) 40 E. White ave. Hamilton

15 Filed 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1924, to 6, 1924

that I last saw him alive on Feb 6 1924

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Dr. Emily Long, M. D.

Feb 7, 1924 (Address) 2718 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Feb 9th 1924

20 UNDERTAKER Fredk Lassahn & Sons

ADDRESS Fullerton

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 8 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83607

CERTIFICATE OF DEATH.

179 D 83607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 10 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Taylor

(a) RESIDENCE No. 723 Kirkes court ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 13/1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alex. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Eleanor Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Jannie Smallwood

(Address) 606 Herbert Alley

15 Filed EB 9 - 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns over almost entire body.

(Child was playing with matches)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Waller, M. D. (Coroner.)

Feb 8/24 192 (Address) 5pl E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Feb 9 1924

20 UNDERTAKER Wm R A Elliott — ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 83608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83608

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1114 Haubert St. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer E. Esterline.

(a) RESIDENCE No. 1114 Haubert St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or ~~divorced~~ — HUSBAND of ~~(or) WIFE of~~ — Ella Esterline.

6 DATE OF BIRTH (month, day, and year) February 15, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Blacksmith.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hanover Pa.

PARENTS

10 NAME OF FATHER: Cornelius Esterline.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania.

12 MAIDEN NAME OF MOTHER: Elizabeth Holden.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: John W. Esterline (brother).
(Address): 9 N. Clinton Street.

15 Filed FEB 9 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M Reinhardt (Coroner), M. D.

Feb, 8. , 1924. (Address) 1014 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C & Co.	2-9 1924
20 UNDERTAKER	ADDRESS
E & B Harle	1156 E West Lt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83609

101-004 D 83609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Jefferson ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Johnson

(a) RESIDENCE. No. 1506 Jefferson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Marg. Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James Johnson 1506 Jefferson St

15 Filed FEB 9 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1924 to Feb 6 1924

that I last saw h[illegible] alive on Feb 6, 1924

and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw J Green M. D.

2-8-1924 (Address) 120 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb 9 1924

20 UNDERTAKER	ADDRESS
Mrs J. Sacks	1302 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83610

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Dallas ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd H. Anthony

(a) RESIDENCE NO. 105 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Molly Anthony

6 DATE OF BIRTH (month, day, and year) Dec 12/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 -	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter Prob

(b) General nature of industry, business, or establishment in which employed (or employer) Equitable Bldg.

(c) Name of employer Equitable Bldg.

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John Anthony

11 BIRTHPLACE OF FATHER (city or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Virginia

(State or country)

14 Informant Mabel Weatherly

(Address) 1527 E. Lombard

Robert F. Harris M.D.

Filed FEB 9 1924 .19 ..... Registrar

~~Burial Permit Clerk~~.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7/ 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 24/ 1923 to Feb 7/ 1924

that I last saw h alive on Feb 6/ 1924

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralytic Hemiplegia

(duration) yrs. 3 mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urin Analysis

(Signed) Edward C Eschinger M. D.

.19 (Address) 1514 2 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery — DATE OF BURIAL Feb 11 1924

20 UNDERTAKER Theodore L White — ADDRESS 183 S Wolfe St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED EXACTLY. PHYSICIANS should write mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83611

CERTIFICATE OF DEATH.

100-006 83611

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 W 33 ST. 13 WARD)

2-FULL NAME Wm J Howden

(a) RESIDENCE NO. 522 W 33 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta Howden

6 DATE OF BIRTH (month, day, and year) Oct 2. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Zacharia Howden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Roberta Howden (Address) 522 W 33 St

15 [illegible] 1924 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1924, to Feb 8, 1924, that I last saw h[illegible] alive on Feb. 8, 1924, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? [illegible] Date of

Was there an autopsy? Dr.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Feb 9, 1924 (Address) 3929 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reelsville Md

DATE OF BURIAL Feb 10 1924

20 UNDERTAKER CHENOWETH & SON,

ADDRESS 3617 CHESTNUT AVE.

B 9 - 1924

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 W 38 ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E McClure

(a) RESIDENCE NO. 921 W 38 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H McClure

6 DATE OF BIRTH (month, day, and year) Dec 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Amos Delozier

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) William H McClure 921 W 38 St

15 Filed FEB 9 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1923 to Feb. 8 1924.

that I last saw her alive on Feb 7. 1924

and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no,

What test confirmed diagnosis? Clinical

(Signed) Karl Stumwell M. D.

2/8, 1924 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Feb. 11 1924
20 UNDERTAKER	ADDRESS
CRENOWETH & SON	2617 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

299

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83613

CERTIFICATE OF DEATH.

D 83613

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Md. General Hosp

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

2-FULL NAME Mrs. Katherine Kilbaugh

(a) RESIDENCE NO. 3570 Poole ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur C Kilbaugh

6 DATE OF BIRTH (month, day, and year): Jan. 28 1869

7 AGE: Years 55 Months ..... Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md

PARENTS

10 NAME OF FATHER: Antone Rueberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Matilda Stoeckle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Deceased
(Address) .....

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

FEB 9 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to Feb. 8, 1924.

That I last saw her alive on Feb. 7, 1924.

and that death occurred, on the date stated above, at between 4 & 6 42 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Valvular Decompensation

Myocarditis

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Lab. + Clinical

(Signed) Jno A Tompkins, M. D.

, 19 (Address) MD Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wards Chapel Balto Co

DATE OF BURIAL: Feb 10 1924

20 UNDERTAKER: CHENOWETH & SON,

ADDRESS: 3617 CHESTNUT AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83614

D 83614

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1532 N Madeira ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie McQueeney

(a) RESIDENCE. No. 1532 N Madeira ST., 8 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	70	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Peter McQueeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Goldrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mollie McQueeney

(Address) 1032 N Madeira

15 Filed FEB 9 - 1924 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/8/24 19

17

I HEREBY CERTIFY, That I attended deceased from Jan 19 19 24, to Feb 8 19 24,

that I last saw her alive on Feb 8 19 24,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) A. F. Herzog M.D. M. D.

2/9 19 24 (Address) 1305 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feby 11 1924
20 UNDERTAKER John Ellis	ADDRESS 2908 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

D 83615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83615

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Scott

(a) Residence No. 746 Bradley St, St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS:

10-NAME OF FATHER, Theodore Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto., Md.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto., Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed FEB 9 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 18 19 24 to February 6 19 24

that I last saw her alive on February 5 19 24

and that death occurred, on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

(Terminal) Broncho Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Right Breast

General Metastasis (Duration) 1 yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Sutton, M. D

2-6-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	2-9-, 19 24
20-UNDERTAKER,	ADDRESS
Daniel Easter,	Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83616

CERTIFICATE OF DEATH.

37 D 83616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 N collington ave WARD) 7

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L Thompson

(a) RESIDENCE NO. 520 N collington ave WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry F Thompson

6 DATE OF BIRTH (month, day, and year) Dec 11-1882

7 AGE 42 Years	Months 1	Days 4	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Sandford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry Thompson
(Address) 520 N Collington ave

FEB 9-1924 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20-24, 1924, to February 8, 1924,
that I last saw her alive on February 8, 1924,
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis
Phthisis Florida
(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
General Paralysis
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Dreyer M. D.
, 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 11 1924
20 UNDERTAKER	ADDRESS
Wm C. Miller	2334 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT BECOMES A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83617

CERTIFICATE OF DEATH.

49 D 83617

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 Bolton St., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Hooper

(a) RESIDENCE NO. 1626 Bolton ST., 14 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? 71 yrs. 2 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Rau Hooper

6 DATE OF BIRTH (month, day, and year) Dec-6-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jas. A. Hooper

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Holloway

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mrs Margaret R. Hooper (wife) (husband)

(Address) 1626 Bolton St

15 Filed FEB 9 - 1924

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17

I HEREBY CERTIFY, That I attended deceased from July, 1923, to Feb. 8, 1924.

that I last saw him alive on ....., 19....;

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma of Prostate Gland, with general metastases.

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Frequent hematuria — (duration) about 8 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G Carroll Lockard, M. D.

Feb. 9. 1924 (Address) 4 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy

DATE OF BURIAL Feb 9 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R
mation should be carefully supplied. AGE should be stated EXACTLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 83618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 570 S. 14 ST., 16 WARD) 10

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Idella Kausch

(Residence in Baltimore: No. 570 S. 14 St.; .....yrs., ...mos. .....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: Nov. 15, 1921 (Month) (Day) (Year)

7-AGE: 2 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: ——
(b) General nature of industry, business, or establishment in which employed (or employer): ——

9-BIRTHPLACE, (State or Country): Balto.

PARENTS.

10-NAME OF FATHER: Domenic Kausch

11-BIRTHPLACE OF FATHER (State or Country): Austria-Hungary

12-MAIDEN NAME OF MOTHER: Anna Klug

13-BIRTHPLACE OF MOTHER (State or Country): Austria-Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Domenic Kausch.

(Address) 570 S. 14th St.

15- FEB 9 - 1924 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF ~~DEATH~~: Feb. 8, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 16 1924, to Feb. 8 1924, that I saw h— alive on Feb. 8 1924, and that death occurred, on the date stated above, at 10 28 A.M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia ?

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. L. Platt M. D.

2-9, 1924 (Address) 801 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Feb. 9, 1924

20-UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

(Abel.) See Letter in file 2-12-24

D 83619

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 83619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Gen'l Hosp'l. ST., 22 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Abel

(a) RESIDENCE No. 657 Barre St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married but separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3- 1886

7 AGE: Years 37 | Months 9 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas Abel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Maggie Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Jno Abel 657 Barre St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar.

FEB 9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.8.24 19

17 I HEREBY CERTIFY, That I attended deceased from 12.18.23 19 ..... to 2.8.24 19 ....., that I last saw him alive on 2.8.24 ..... 19 ....., and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma

Pulmonal Sarcomatosis

(Final Cause)

..... (duration) ..... yrs. 11 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1.3.24

Was there an autopsy? no Clinical diagnosis.

What test confirmed diagnosis?

(Signed) Jno C Stamp Jr M. D.

, 19 (Address) Mt Gen'l Hosp'l

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 11 1924
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	1038 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ASK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 83620

B 83620

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 N. Luzerne Ave ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Adelaide Haven

(a) RESIDENCE NO. 120 N. Luzerne Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore H. Haven

6 DATE OF BIRTH (month, day, and year) Mar 4 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Georgetown
(State or country) D. C.

PARENTS

10 NAME OF FATHER Wm H. Ritter

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Tuseth

13 BIRTHPLACE OF MOTHER (city or town) Penna
(State or country)

14 Informant Theodore H. Haven
(Address) 120 N. Luzerne Ave

15 Feb 9 - 1924 Robert R. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb 8, 1924

that I last saw her alive on Feb 8, 1924

and that death occurred, on the date stated above, at 7:- m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Symptoms

(Signed) Louis V. Zapf M.D.

2/9, 1924 (Address) 1601 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Feb 11 1924
20 UNDERTAKER	ADDRESS
Leitch & Co	Baltimore

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT BECOMES A PERMANENT RECORD. EACH mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D 83621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83621

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Howard A. Kelly Hosp

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST., Baltimore WARD)

2-FULL NAME Mrs. Sallie C. Norman.

(a) RESIDENCE NO. 1418 Eutaw Place ST., WARD Lexington N. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Capers Norman

6 DATE OF BIRTH (month, day, and year): Feb. Aug 20 1856

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Lexington N. C.

PARENTS

10 NAME OF FATHER: Jessie H. Hargrave

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lexington N. C.

12 MAIDEN NAME OF MOTHER: Martha Clement

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mocksville N. C.

14 Informant: Mrs. C. C. Hargrave
(Address) Lexington N. C.

15 FEB 9 - 1924 Robert P. Harrison, ... 19 ... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1924, to Feb. 9, 1924, that I last saw h alive on Feb. 9, 7 a.m., 1924, and that death occurred, on the date stated above, at 8.01 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) ... yrs. ... mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

Carcinoma Uteri (duration) 1(?) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Jan. 31.

Was there an autopsy? no

What test confirmed diagnosis? Blood. Chemistry

(Signed) Beckham Howe M. D.

Feb. 9, 1924 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lexington North Carolina — DATE OF BURIAL: Feby 9 1924

20 UNDERTAKER: Elias G. Black — ADDRESS: 742 W. North ave

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shou CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83622

CERTIFICATE OF DEATH.

12 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3015 St. Paul St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Lacy

(a) Residence No. 3015 St. Paul St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Frances Lacy

6-DATE OF BIRTH (month, day and year) Mar. 19, 1868

7-AGE.				If LESS than 1 day,
55 yrs.	10 mos.	19 ds.		....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Foundryman

(b) General nature of industry, business, or establishment in which employed (or employer): J. J. Lacy Co.

(c) Name of employer: 047

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: James J. Lacy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Cork, Ireland

12-MAIDEN NAME OF MOTHER: Catherine Hurley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Harrisburg, Pa.

11- (Informant): Chas. P. Coady

(Address): 3028 St. Paul St.

15- Filed FEB 9 1924 16- Robert F. Harris Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 7th/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 12 1923 to Feb 7 1924

that I last saw him alive on Feb 7 1924

and that death occurred, on the date stated above, at 1.15 P.m.

The CAUSE OF DEATH* was as follows:

Sub-acute Bacterial Endo-Carditis (Blood Cultures showed Staph. Viridans)

(Duration) -- yrs. 6 mos. -- ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Interstitial

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Test

(Signed) Jefferis Busk M. D.

Feb 8, 1924 (Address) 2 E. 4 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cathedral Cemetery	2/11, 19 24
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83623 ✓ x 43 D 83623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home Infirmary. REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Byron Bishop

(a) RESIDENCE NO. Wildwood NJ ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 2 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 13 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Distribution Mgr. 00

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer "North American" Phila

9 BIRTHPLACE (city or town) Snow Hill (State or country) MD

PARENTS

10 NAME OF FATHER George W Bishop

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) MD

12 MAIDEN NAME OF MOTHER Zeporah Ellen Rowley

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) MD

14 Informant John S Bishop
(Address) 930 Calvert St Balto.

15 Filed FEB 9 1924, 19 ..... Robert F. Harrison, Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from JAN 29, 1924, to FEB 8, 1924, that I last saw h/w alive on FEB 5, 1924, and that death occurred, on the date stated above, at 10.18 P m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF TONSIL - BASE OF TONGUE

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) GENERAL CARCINOMATOSIS

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? WILD WOOD NJ

Did an operation precede death? Yes Date of ?

Was there an autopsy? No

What test confirmed diagnosis? MICR EXAM OF CANCER

(Signed) Allen J. Kirkwood, M. D.

, 19 (Address) 730 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Snow Hill Md — DATE OF BURIAL 2/10 1924

20 UNDERTAKER Henry W. Means & Son — ADDRESS 505 Calvert St

FEB 9 - 1924

PLEASE WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OccUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83624

100-00 D 83624

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 508 E Barney ST., 24 WARD)

2-FULL NAME Beatrice Louise McNamey

(a) RESIDENCE No. 508 E Barney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1.25.24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto-
(State or country)

PARENTS

10 NAME OF FATHER Hiram D. McNamey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Julia Schulte

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mr H D McNamey
(Address) 508 E Barney St

15 Filed FEB 9 - 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.8 1924

17 I HEREBY CERTIFY, That I attended deceased from 2.5, 1924, to 2.8, 1924, that I last saw h[illegible] alive on 2.8, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L J Burlington, M. D.

, 19 (Address) 102 E Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 2/9 1924

20 UNDERTAKER J. Frew McCully

ADDRESS 130 C. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES must be made in ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83625

CERTIFICATE OF DEATH. 57

D 83625

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1536 N. Bruce ST. 15 WARD)

2-FULL NAME Elizabeth Kent

(a) RESIDENCE NO. 1536 N. Bruce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Kent

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 44 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Benj. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Lucinda Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: James Kent

(Address) 1536 N. Bruce st

FEB 9 - 1924

Filed ....., 19 ..... Robert F. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 5* 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1924, to Feb 6, 1924, that I last saw him alive on Feb 5*, 1924, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Urine -

(Signed) Harry F. Brown M. D.

2/7, 1924 (Address) 501 Preston st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 10 1924

20 UNDERTAKER: Jas. A. Farrell — ADDRESS: 2319 Linden Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83626

CERTIFICATE OF DEATH.

101-001 D 83626

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1105 Parrish (St.) 16 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen Johnson

(a) RESIDENCE. No. 1105 Parrish St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
abt 62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fish Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Fredericktown Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fredericktown

14 Informant: Rev. Irving Gray
(Address) 1127 N. Calhoun St

15 Filed 19 Robert P. Harrison Registrar

FEB 9 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 7, 1924, that I last saw h[illegible] alive on 2-6-24, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Grippe (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1105 Parrish

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. R. Boykin, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt St Lukes Cemetery	Feb 10 1924
20 UNDERTAKER	ADDRESS
Mt Jos. C. Farrell Fredericktown Md	2319 Division

IMPORTANT.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83627

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1311 Hanover St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas J. Eagan

(a) Residence No. 1311 Hanover St., 23 Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Eagan

6-DATE OF BIRTH (month, day and year) May 18 1867

7-AGE. 56 yrs. 8 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Policeman
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 061
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS:
10-NAME OF FATHER, Wm Eagan
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Cath Murray
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-
(Informant) Annie Eagan
(Address) 1311 Hanover St

15-
Filed FEB 9 - 1924 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 7-24

17- I HEREBY CERTIFY, That I attended deceased from July — 1917 to July 7 1924

that I last saw him alive on July 7th 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) 7 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Leichhardt M. D.

19 (Address) 1300 E Chase

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL, Feb 11 19 24

20-UNDERTAKER. F. A. Krause & Son — ADDRESS 703 Hanover

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

16936 83628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D 83628

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Churchill Smith

(a) RESIDENCE No. 1147 New Hampshire Ave WARD Washington D.C.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER E. H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. H.

12 MAIDEN NAME OF MOTHER E. M. Kinsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Hampshire

14 Informant JOHNS HOPKINS HOSPITAL

(Address) Record

15 FEB 1 0 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to Feb 9 - 1924, that I last saw he alive on Feb 9 - 1924, and that death occurred, on the date stated above, at 3 00 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. — DATE OF BURIAL 2/11 1924

20 UNDERTAKER Isaac Birch — ADDRESS 3034-M St Washington DC

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83629

CERTIFICATE OF DEATH.

X 74

D 83629

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 24th WARD)

2-FULL NAME Julia Ryan (or Josephine)

(a) RESIDENCE NO. Mount Hope Retreat ST., 24th WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? Born yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb 25 - 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer) Religious work

(c) Name of employer

9 BIRTHPLACE (city or town) (?) Co Tipperary

(State or country) Ireland

PARENTS

10 NAME OF FATHER Philip Ryan

11 BIRTHPLACE OF FATHER (city or town) Co Tipperary

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia McDonald

13 BIRTHPLACE OF MOTHER (city or town) Co Tipperary

(State or country) Ireland

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Balto Md

FEB 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 1923, to Feb 8th, 1924,

that I last saw her alive on Feb 8th, 1924,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

R. Hemiplegia - Post Cerebral Hemorrhage

abt (duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Emmettsburg Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Feb 9th, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery — DATE OF BURIAL Feb 10 1924

20 UNDERTAKER [illegible] MOWEN COMPANY WILLIAM F. MOWEN, Successor — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE, WHEN FILLED OUT, SHOULD BE PRESERVED UNTIL RECORDED. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83630

CERTIFICATE OF DEATH.

90 D 83630

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Linden Ave ST. 11 WARD)

2-FULL NAME Albert Vogues

(a) RESIDENCE NO. 712 Linden Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Vogues

6 DATE OF BIRTH (month, day, and year): Unknown 1844 or 5

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Caroline Vogues

(Address) 712 Linden Ave

15 Filed FEB 1 01924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8- 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1924, to Feb 8th, 1924,

that I last saw h[illegible] alive on Feb 7th, 1924,

and that death occurred, on the date stated above, at 5.50 A m.

The CAUSE OF DEATH* was as follows:

Val. Dis. of Heart (Purpura)

Due to Age -

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) ..... M. D.

, 19 (Address) 607 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: 2/10 1924

20 UNDERTAKER: Samuel Hensley

ADDRESS 578 N Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83631

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 N Calvert St | WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rogers

(a) RESIDENCE NO. 625 N Calvert ST WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Daniel Gunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Curtin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Eugene Burns (Address) 625 N Calvert St

15 FEB 1 01924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1922 to Feb 8 1924

that I last saw her alive on Feb 8 1924

and that death occurred, on the date stated above, at 1150 AM m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? W

Did an operation precede death? W Date of

Was there an autopsy?

What test confirmed diagnosis? Palpation & Observation

(Signed) J. Montgomery, M. D.

, 19 (Address) 3 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shiloh Pa	Feb 11 1924
20 UNDERTAKER Martin Bakey Co	ADDRESS 824 W North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Muir

CERTIFICATE OF DEATH.

D 83632

71-005 83632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Muir

(a) RESIDENCE NO. 1109 Barclay St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): July 26-1863

7 AGE: Years 60 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oil

(b) General nature of industry, business, or establishment in which employed (or employer): Mate on Boat.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Muir.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mariah Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ira Braswell

(Address): Cecil Co

15 Filed 19 Registrar

FEB 1 0 1924 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/8/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/26/24, 19 to 2/8/24, 19, that I last saw h[illegible]live on 2/8/24, 19 and that death occurred, on the date stated above, at 3:06 P. m.

The CAUSE OF DEATH* was as follows:

Bacillus - Specific Meningitis (Pneumococcus)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Necropsy

(Signed) R. W. Dilley, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount Somerset Co Md

DATE OF BURIAL: Feb 11 1924

20 UNDERTAKER: M Trahey & Son.

ADDRESS: 827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83633

123 D 83633

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 N. Eden St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Carman

(a) Residence No. 1424 N. Eden St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Harry E Carman

6-DATE OF BIRTH (month, day and year) Feb. 11 1866

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), B. A. Co. Md

PARENTS.

10-NAME OF FATHER Andrew Osborne

11-BIRTHPLACE OF FATHER (city or town) (State or Country) B. A. Co. Md

12-MAIDEN NAME OF MOTHER Margaret Faulkner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), B. A. Co. Md

14-

(Informant) Walter E. Carman

(Address) 1424 N. Eden

15- FEB 1 1924

Filed ....., 192 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 7 Feb. 1924

17- I HEREBY CERTIFY, That I attended deceased from 2d Feb. 1924, to 7th Feb. 1924, that I last saw her alive on 6 Feb. a 24 1924 P and that death occurred, on the date stated above, at 1115 a.m.

The CAUSE OF DEATH* was as follows:

Acute hepatic Colic

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Cholelithiasis

(Duration) 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of ..... was advised but patient refused

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. L. Sandrock, M. D.

9 Feb. 1924 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, Feb 10 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 N North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83634

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Leffler

(a) RESIDENCE NO. 2713 Hugo Cenk ST., ... WARD ...
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word) Married

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Wm H Leffler

6 DATE OF BIRTH (month, day, and year) Apr 18. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mildred M Leffler (Address) 2512 Harford Road

15 FEB 10 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/8 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Feb 8, 1924, that I last saw her alive on Feb 8, 1924, and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis - peritonitis.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Sub-diaphragmatic abscess

2 days (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Feb 5-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) John K. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Feb 11 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83635

CERTIFICATE OF DEATH.

91-602

D 83635

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister Mary Wilhelma Schaefer

(Residence in Baltimore: No. Aisquith St & Ashland Ave St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, August 24, 1845
(Month) (Day) (Year)

7-AGE, 78 yrs. 5 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Schaefer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Scheier

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Bernarda

(Address) Notre Dame Aisquith St

15- ROBERT R. KRAUTER,

FEB 10 1924 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 4, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1923, to February 1924, that I saw h.r. alive on Febry 3 1924, and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

Terminal Pneumonia

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Finke M. D.

Feb 7, 1924 (Address) 1106 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Notch Cliff Md.	Feb. 11, 1924
20-UNDERTAKER	**ADDRESS**
Frank A. Fink	915 E. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83636

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-901 83636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yetta Karminsky

(a) RESIDENCE No 1739 E. Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Karminsky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Sklavan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rifka ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Karminsky
(Address) 1739 E. Balto. Md

15 FEB 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chr. Nephritis- arteriosclerosis (duration) ..... yrs. ..... mos ..... ds.

(Signed) ..... (Coroner) ..., M. D.

Feb 9/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nelson Herring Rm	2/10 1924

20 UNDERTAKER ADDRESS
Jack Lewis 1439 E. Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 516 W. West St., ... St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lillian Steinberg .....

(a) Residence No. 516 W. West St ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6-DATE OF BIRTH (month, day and year) Oct. 7th-05

7-AGE. 18 yrs. 4 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 009

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Norfolk, Va

PARENTS.

10-NAME OF FATHER, Abraham Steinberg

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Pearl Kirvis

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant)..... J. Lewis .....

(Address)..... 1439 E. Balto., ...

15- FEB 1 01924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-9-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb 9, 1924

that I last saw h.. alive on.. Feb 9, 1924

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Inflammation

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell, M. D.

Feb 10, 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Herring Run	Feb 10. 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E. Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83638

CERTIFICATE OF DEATH.

89 D 83638

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 310 S Caroline Street St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Zala Mitnick

(a) Residence No. 310 S Caroline St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis Mitnick

6-DATE OF BIRTH (month, day and year) Unkown

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Joseph Highkin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unkown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore St

15- FEB 1 0 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2. 8. 24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1924, to Feb. 5, 1924, that I last saw h. alive on Feb. 5, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
arterio-Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina-Pectoris

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D.A. Nicholson, M. D.

, 19 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL, 2, 10 24, 19....

20-UNDERTAKER. Jack Lewis 1439 E Balto St

ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

083639

HEALTH DEPARTMENT—CITY OF BALTIMORE

083639

CERTIFICATE OF DEATH.

127

1-PLACE OF DEATH Maryland General Hospital.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Linden Ave & Madison ST., 70 WARD)

2-FULL NAME Mrs Bertha Rossmarcke.

(a) RESIDENCE No. 3929 Edmondson Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 22 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 07

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Joseph Fruchsmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Julia Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Deceased.
(Address) 3929 Edmondson Ave

15 Filed FEB 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9. 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to Feb 9, 1924
that I last saw her alive on Feb 9, 1924.
and that death occurred, on the date stated above, at 5:12 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis.
Chronic Pancreatitis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction due to intestinal Adhesions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes, Date of Feb 5, 1924

Was there an autopsy? Partial Autopsy.

What test confirmed diagnosis?

(Signed) Jos A Stamptier, M. D.

2/9, 1924 (Address) 10 Penn Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Feb 12 1924
20 UNDERTAKER Jos B Cook	ADDRESS 1003 N Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83640

HEALTH DEPARTMENT—CITY OF BALTIMORE

33

D 83640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara E. Loetell

(a) RESIDENCE NO. 823 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Rott. C. Loetell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Anna Tufts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Mr. Loetell

(Address) 823 E. Eager

15 Filed FEB 1 0 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1923, to Feb. 9, 1924,

that I last saw her alive on Feb. 9, 1924

and that death occurred, on the date stated above, at 1.50 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 5, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Walter Southerland, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 2/12 1924

20 UNDERTAKER: J. F. McCully

ADDRESS: 130 E. Fort

N. B. WARNING—Any person who wilfully makes a false statement in this certificate shall be guilty of a misdemeanor. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83641

CERTIFICATE OF DEATH.

23 D 83641

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 27 WARD)

2-FULL NAME Thomas Jew Shipley

(a) RESIDENCE NO. 5013 Park Heights Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Race track attendant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Randallstown Md (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas C Shipley

11 BIRTHPLACE OF FATHER (city or town) Randallstown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marcella Cross

13 BIRTHPLACE OF MOTHER (city or town) Randallstown (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ....., 19 ..... ROBERT R. KRAUTER Registrar

FEB 1 0 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924, to Feb. 10, 1924, that I last saw h.im alive on Feb. 9, 1924, and that death occurred, on the date stated above, at 8 52 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis (?)

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Singultus

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? North Carolina

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive Roslyn Md

DATE OF BURIAL Feb 12 1924

20 UNDERTAKER Jos R. Cook

ADDRESS 1003 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably
Lethargic

Spec—12-23-21—E.B.R.S.—400 Bks.

Casey.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 101-001

D 83642 D 83642

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan Casey

(a) Residence No. 113 N. Mulberry St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? --yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	W.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of --------

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto, Md

9-BIRTHPLACE (city or town) (State or Country).

PARENTS.

10-NAME OF FATHER, Henry Casey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do not know

14- (Informant) Agnes Renehan

(Address) 113 N. Mulberry St.

15- FEB 1 01924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 16 1924, to Feb. 9 1924

that I last saw him alive on Feb. 9 1924, and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

Chronic Myocarditis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. & Autopsy

(Signed) H. O. Harper M. D

, 19 (Address) St. Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL, 2/12 1924

20-UNDERTAKER, Henry W. Mears & Son

ADDRESS 805 N. Calvert

EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 83643 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 83643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St., 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Kreeger

(a) RESIDENCE NO. 3901 Lloyd Ave ST., Arlington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	21	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John H. Kreeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Susie McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mr. Alexander Kreeger

(Address) 3901 Lloyd Avenue

15 FEB 1 01924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-3, 1923, to 2-9, 1924, that I last saw her alive on 2-9, 1924, and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows: Acute Follicular Tonsillitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-4-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Hammond Wilson, M.D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	2/12 24
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

N. B.—WHITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state name should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very imprtant. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83644

CERTIFICATE OF DEATH.

X 44 ✓

D 83644

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Or Institution) ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Clayton

(a) RESIDENCE NO. Elkridge Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 077

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. W Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Anna McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Univ. Hospital Baltimore (Address)

15 FEB 1 01924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1924, to Feb. 9, 1924,

that I last saw her alive on Feb 9, 1924,

and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

(Stomach)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Jan 31, 1924

(Exploratory Laparotomy)

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab Findings

(Signed) David R. Newcomer M. D.

Feb 9, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Laurel Md

DATE OF BURIAL Feb 11 1924

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 1252 North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Kelly, Lansmdl Fairmont

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83645

CERTIFICATE OF DEATH.

33 D 83645

1-PLACE OF DEATH

City of BALTIMORE: (No. Bowleys + Gunthen Lane St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Hilda M. Bankowsky.

(a) Residence No... Bowleys + Gunthen Lane St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Einel H. Bankowsky

6-DATE OF BIRTH (month, day and year) Jan 4, 1905

7-AGE, 19 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Work

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Einel H. Bankowsky

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Martha M. Wasserman

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Einel H. Bankowsky

(Address) Bowleys + Gunthen Lane

15- FILED FEB 1 01924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Feb 8, 1924, that I last saw h.. alive on Feb 8, 1924, and that death occurred, on the date stated above, at 3 P.M. The CAUSE OF DEATH* was as follows:

Interstitial Peritonitis

(Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) W. W. Kelly, M. D.

, 19 (Address) 10 N Linwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL, Feb 11, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 602 E. North ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Sara F. Perel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83646

CERTIFICATE OF DEATH.

5 90

D 83646

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 109 Aisquith St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Feige Perel

(a) Residence No. 109 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 88 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Isaac Feldman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Blumie Feldman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Abraham Perel

(Address) 109 E. Balto St

15- FEB 1 0 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/9/24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1 24 to Feb. 9 24, that I last saw h.. alive on Feb. 8 24, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. E. Bayless, M. D.

, 19 (Address) 720 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Southern Ave DATE OF BURIAL, 2/10, 1924

20-UNDERTAKER, Sol Levinson & Bro ADDRESS 112 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83647 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83647

CERTIFICATE OF DEATH.

Registered No. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. 3732 E Lombard St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Monbrooks

(a) Residence No. 3732 E Lombard St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Monbrooks

6-DATE OF BIRTH (month, day and year) July 1844

7-AGE, 76 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Woman

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. William Hahn

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penn

12-MAIDEN NAME OF MOTHER. Dina Fell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Mrs. Mary Patterson

(Address) 3732 E. Lombard St.

15- Filed FEB 1 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 9 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 18th, 1924, to Feb 9th, 1924, that I last saw h[illegible] alive on Feb 7 1924, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Fold, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Carmel — DATE OF BURIAL, Feb [illegible], 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 S. Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Chronic

Spec.—8-24-14—M. & T.—2000 Bks.

D 83648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83648

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 E. 20th. St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances J. Mc Ginn

(Residence in Baltimore: No. 505 E. 20th St.; Lifetime yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan. (Month) 19 (Day), 1923 (Year)

X 7-AGE, 1 yrs. — mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Md Baltimore City

PARENTS.

10-NAME OF FATHER Richard H. Mc Ginn

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Margaret Collins

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R H Mc Ginn

(Address) 505 E. 20th St

15- FEB 10 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 8 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 7 1924, to Feby 8 1924, that I saw h[illegible] alive on Feby. 8 1924, and that death occurred, on the date stated above, at 1.25 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas R. Magness M. D.

Feby 8, 1924 (Address) 14 E. Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL, 2/11, 1924

20-UNDERTAKER Mas F. Evans & Son ADDRESS 1181 Dist Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D 83649

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Stepney

(a) Residence No. 2211 McElderry St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1898

7-AGE.	If LESS than 1 day.
26 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Janitor

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto., Md

PARENTS.

10-NAME OF FATHER. James Stepney

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Municipal Hospital Records.

(Address)

FEB 1 01924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 4 19 24 to February 8 19 24 that I last saw h... im alive on February 8 19 24 and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Dixon M. D

2-9-19 24 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodbury cemetery	Feb 12 1924
20-UNDERTAKER.	ADDRESS
Edward Bryan	1831 Orleans st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—2,000,000.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83650

CERTIFICATE OF DEATH.

101-001 ✓

Registered No. D 83650

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 E Madison St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Young

(a) Residence No. 1509 E Madison St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1867

7-AGE.	If LESS than 1 day,
57 yrs. 6 mos. 6 ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Mary co. Md

PARENTS.

10-NAME OF FATHER, Owen Young

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Anna L. Barnes

(Address) 1509 E Madison St

15- Filed 192 ROBERT R. KRAMER Registrar.

FEBT 01924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 8 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 2, 1924, to Feb 8, 1924, that I last saw h[illegible] alive on Feb 8, 1924 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Dr Ennis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) J. Edward Fisher M. D.

2-8, 1924 (Address) 1612 E monument st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodberry cemetery — DATE OF BURIAL, Feb 11, 1924

20-UNDERTAKER, Edward Bryan — ADDRESS 1631 Carlton st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83651

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83651

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 526 S. Streeper St., 1st Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine E. Eckert

(a) Residence No. 526 S. Streeper St., 1st Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? 61 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fred J. Eckert

6-DATE OF BIRTH (month, day and year) Feb 21 1863

7-AGE, 61 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, John Felter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Margaret Wise

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14- (Informant) Mr. Fred J. Eckert

(Address) 526 S. Streeper St.

15- FEB 1 01924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 8 24

17- I HEREBY CERTIFY, That I attended deceased from Apr 3, 1923, to Feb 8, 1924, that I last saw h[illegible] alive on Jan 15, 1924 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectaris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Hardening

(Signed) D. E. Mahr, M. D.

, 19 (Address) 3015 Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL, Feb 11, 1924

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2068 Eastern

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KEEP FLAT • DO NOT FOLD

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1729 83652

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Carlton st ST.: 18 WARD)

2-FULL NAME Hughes Roan

(a) RESIDENCE. NO. 219 Carlton St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Barber Shop

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Roan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co., Va.

12 MAIDEN NAME OF MOTHER Lucy Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buckingham Co., Va.

14 Informant James Hughes

(Address) 225 Carlton st

15 [illegible]

FEB 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8- 1924

17

I HEREBY CERTIFY, That I attended deceased from 1-22- 1924, to 2-8 1924, that I last saw him alive on 2-7 1924, and that death occurred, on the date stated above, at 11⁰⁰ a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Probably (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 17 Lon. Mount st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dillwyn, Va.	2-11- 1924
20 UNDERTAKER Daniel Easton	ADDRESS 916 Gay st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.F.S.-400 Bks.

D 83653 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

CERTIFICATE OF DEATH.

D 83653

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1809 Little Walsh St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Cimino

(a) Residence No. 1809 Little Walsh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White Italian

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Cimino

6-DATE OF BIRTH (month, day and year) Aug 15 1856

7-AGE. 67 yrs. 5 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Sepino Catalan

PARENTS.

10-NAME OF FATHER. Salvadore Cimino

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Catalan Sicily

12-MAIDEN NAME OF MOTHER. Dora DeFalta

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Catalan Sicily

14- (Informant) Frank Cimbola

(Address) 1809 Little Walsh

FEB 7 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 9-1924

17- I HEREBY CERTIFY, That I attended deceased from February 8, 1924 to Feb 9, 1924

that I last saw h.e alive on Feb 9, 1924

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D

(Address) 1209 Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincent Cem

DATE OF BURIAL. 2-11-1924

20-UNDERTAKER. Daniel Eastern

ADDRESS 916 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83654

CERTIFICATE OF DEATH.

21 D 83654

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones

(a) Residence No. 812 W. Pratt St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15-

Filed FEB 1 0 1924 19.. ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 27 1924 to February 8 1924

that I last saw h. im alive on February 8 1924

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Path. & Autopsy

(Signed) Claude S. Bruce M. D

2-9- 1924 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	2-11 1924
20-UNDERTAKER, Daniel Easton	ADDRESS 912 Gilmore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 83655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier #7. Locust Point. ST. 23 WARD)

2-FULL NAME Melvin Morgan,

(a) RESIDENCE No. 1934 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Structural Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Chicago Bridge
(c) Name of employer & Iron Works.

9 BIRTHPLACE (city or town) (State or country) St. Joseph Mo.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charles O. Riley.
(Address) 121 W. Barre St

15 Filed FEB 1 01924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from a water tank.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Albert Reinhardt, M. D. (Coroner.)

Feb. 10. 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dawn, Missouri — DATE OF BURIAL Feb. 10 1924

20 UNDERTAKER Margaret L. Flynn — ADDRESS 422 Aug. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83656

CERTIFICATE OF DEATH.

X 90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 28th WARD)

2-FULL NAME Rev. Camillus Peter Szybala

(a) RESIDENCE NO. Mount Hope Retreat ST., 28th WARD Phila. Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? 13 yrs. 6 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23rd 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R. C. Priest 018

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (?)
(State or country) Poland.

PARENTS

10 NAME OF FATHER Valentine Szybala

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Baczar Anna

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Poland

14 Informant Rectory of Mt Hope Retreat
(Address) Baltimore Md.

FEB 11 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 5th 1924, to Feb 9 1924, that I last saw him alive on Feb 9 1924, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

abt (duration) 0 yrs. 0 mos 5 ds.

CONTRIBUTORY (Secondary) Paranoia Psychosis

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Feb 7th, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa DATE OF BURIAL Feb 10 1924

20 UNDERTAKER WOODEN & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83657

CERTIFICATE OF DEATH.

1927 D 83657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Peach al ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Cooper.

(a) RESIDENCE. No. 914 Peach al ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Supposed mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Cooper

6 DATE OF BIRTH (month, day, and year) Mar 5 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Richard Cooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U.S.

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) Unk
(State or country)

14 Informant Henry Cooper
(Address) 914 Peach ale

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar
FEB 1 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/5, 1924, to 2/7, 1924, that I last saw h[illegible] alive on 2/7, 1924, and that death occurred, on the date stated above, at 1115 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. E. Smith, M. D.

2/8, 1924 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	2-11 1924
20 UNDERTAKER John A Toadvine	ADDRESS 143 Uniform Av

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83658 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83658

CERTIFICATE OF DEATH. 25129

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Hollinsperry Rd W Wood St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chapman Jackson

(Residence in Baltimore: No. Hollinsperry Rd St., 5 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	Colored	Married

6-DATE OF BIRTH. unknown ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
69 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer). Retired

9-BIRTHPLACE, (State or Country). Balto Co.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Jackson

(Address) 824 Sharp St

FEB 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 8 ..... 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or Inquiry.) find that said deceased came to Dy death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) James H. Foulon M. D. (Coroner.)

2 8 1924 (Address) Todd chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Feb 12 1924
20-UNDERTAKER.	ADDRESS
John H. Foulon	1412 Pitcher St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 33659

CERTIFICATE OF DEATH.

101-001 D 33659

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 704 W Franklin St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie Frances

(a) Residence No..... 704 W Franklin St., ... Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1877

7-AGE, 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... Ill

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Peter Francis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), md

12-MAIDEN NAME OF MOTHER, Louise —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md

14- (Informant) Sadie Pinder

(Address) 704 W. Franklin

FEB 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Feb 7, 1924, that I last saw h[illegible] alive on Feb 7, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Frank D. Fowler, M. D.

Feb 10, 1924 (Address) 722 Maple Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL? Mt Auburn — DATE OF BURIAL, Feb 11, 1924

20-UNDERTAKER, John H. Swadener — ADDRESS 142 Ostend St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83660

101-001 ✓

D 83660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 Fleet ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boleslaw Kujawa

(a) RESIDENCE NO. 2319 Fleet ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Walter Kujawa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sophia Bykowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Walter Kujawa

(Address) 2319 Fleet

15 Filed FEB 1 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1924, to Feb. 9, 1924, that I last saw him alive on Feb 9, 1924, and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. P. Kerr, M. D.

2/9/24 (Address) 4085 Patapsco Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Feb 11 19 24
20 UNDERTAKER	ADDRESS
J. F. Ozgunski	1350 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83661

CERTIFICATE OF DEATH.

24 D 83661

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3126 Stanford Road ST., 17 WARD)

2-FULL NAME Marian L. Kirk

(a) RESIDENCE NO. 3126 Stanford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If ~~married~~, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of H. H. Kirk

6 DATE OF BIRTH (month, day, and year) August 9 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER David Happoldt

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Dr Robert S Kirk
(Address) 3126 Stanford Ave

Filed FEB 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1923, to July 10 1924, that I last saw h~~e~~r alive on July 9 1924, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Uremia (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Roderick L. Dorsey M. D.

, 19 (Address) 28 W. Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feb 12 1924

20 UNDERTAKER H E Stuffed ADDRESS 1512 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—B1&T—1500 Blks.

D 83662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83662

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. ; WARD)

2-FULL NAME Arthur Gogel

(a) RESIDENCE NO. 68 Nassau St New York WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
?	35 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewelry Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman.

(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hospital Record
(Address)

Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/24

17 I HEREBY CERTIFY, That I attended deceased from 2/8/24, 19..., to 2/11/24, 19..., that I last saw him alive on 2/10/24, 19..., and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis
(Ruptured & gangrenous).

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of appendectomy & drainage 2/8/24

Was there an autopsy? No

What test confirmed diagnosis? Gross & Microscopic

(Signed) K. N. Foley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lewis Mills	2/11/24
20 UNDERTAKER	ADDRESS
Wm. A. Farley	Fulton & Fayette

N. B.—WHERE DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, THE NAME OF THE INSTITUTION should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

T 101-001 ✓ D 83663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospital ST., 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Gladden

(a) RESIDENCE NO. North Bend Rd, Catonsville ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Ann Gross

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
abt 65 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coach. Jr 02

(b) General nature of industry, business, or establishment in which employed (or employer) J. Abner Saylor's residence

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emory Gladden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clementine Elbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. Abner Saylor
(Address) 2816 Paul St.

15 FEB 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9-1924

17 I HEREBY CERTIFY, That I attended deceased from 2-4-, 1924, to 2-9-, 1924, that I last saw him alive on 2-9-, 1924 and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. D. Parr, M. D.

2/11, 1924 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Feb 13 1924

20 UNDERTAKER John Gobliewicz — ADDRESS 435 S. Fremont St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83664

CERTIFICATE OF DEATH.

D 83664

124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH German Aged Home

CITY OF BALTIMORE: No. N E Cor Balto + Payson ST. 20 WARD)

2-FULL NAME Robert Zorn

(a) RESIDENCE. No. N. E. Cor Balto Payson ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. mos ds.

be stated EXACTLY. PHYSICIANS should state
be properly classified. Exact statement of OCCUPA-
of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Augusta Zorn

6 DATE OF BIRTH (month, day, and year) Jan 31- 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
80	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 80

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Posen Germany

PARENTS

10 NAME OF FATHER Carl Zorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Ziemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Records German Aged Home N E Balto + Payson St

Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28th, 1924, to Feb 4th, 1924, that I last saw h.. alive on Feb 2th, 19.., and that death occurred, on the date stated above, at 7 50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John L Hoff. M. D.

2/11, 1924 (Address) 1843 N. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 13 1924
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W Balto

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83665

CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Briscoe ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Pabst

(a) RESIDENCE NO. 1015 Briscoe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Pabst

6 DATE OF BIRTH (month, day, and year) Jan 14. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Dietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk

14 Informant Frederick W. Pabst

(Address) 1015 Briscoe St.

15 FEB 7 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Feb 7, 1924.

that I last saw her alive on Feb 7, 1924.

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Intestitis (Chronic)

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Anemia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2/8, 1924 (Address) 517 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feb. 11 1924.

20 UNDERTAKER Mr. & Mrs. John M. Teufel & Son — ADDRESS 801 W. Fayette

N. B. WHITE LEAFLET, WITH UNDERTAKER'S CERTIFICATE, should be carefully preserved by undertaker. INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

D 83666

CERTIFICATE OF DEATH.

D 83666

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1323 W. Lombard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Virginia Grace

(Residence in Baltimore: No. 1323 W. Lombard St.; 12 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widowed

6-DATE OF BIRTH, October 26 (Month) (Day), 1869 (Year)

7-AGE, 54 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Hinton

11-BIRTHPLACE OF FATHER (State or Country). Balto. Co Md.

12-MAIDEN NAME OF MOTHER Emma A. Cooper

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sue M. Garrett

(Address) 2015 Wilhelm St

15- FEB 11 1924 Filed ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 9th (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1923, to Feb 9 1924, that I saw her alive on Feb 4 1924, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 2 yrs. 6 mos. ds.

(Signed) Edwin K. Ballard M. D.

Feb 9..., 1924 (Address) 1622 Mt. Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 11..., 1924

20-UNDERTAKER Josiah Legar — ADDRESS 1600 W North Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83667

CERTIFICATE OF DEATH.

22 D 83667

1-PLACE OF DEATH Homewood Apts

CITY OF BALTIMORE: (No. Charles & 31st St. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Muriel Gascoyne

(a) RESIDENCE NO. 31st & Charles St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word) Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) July 3rd 1912

7 AGE Years 11 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER W. J. Gascoyne Jr

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va

12 MAIDEN NAME OF MOTHER Janet Bond

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant (Address) W. J. Gascoyne Jr Homewood Apts

15 FEB 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1924, to Feb 10, 1924,

that I last saw her alive on Feb 10, 1924,

and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Poliomyelitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Meyer Jr, M. D.

2/10, 1924 (Address) 2638 E Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Feb 12 1924

20 UNDERTAKER Henry Hankins & Son

ADDRESS Orchard & Greenmount

N. B.—WHERE BLANKS APPEAR, WITH UNKNOWN INFORMATION, THIS STATEMENT IS WORTHLESS AS A RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 83668

HEALTH DEPARTMENT—CITY OF BALTIMORE

001 ✓

CERTIFICATE OF DEATH.

14 D 83668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 E. Preston ST., 8 WARD)

2-FULL NAME Mary R. Wiseman

(a) RESIDENCE No. 2033 E. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNABBREVIATED WORDS. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of James H Shareck

6 DATE OF BIRTH (month, day, and year) March 12, 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Samuel H. Wiseman

(Address) 2033 E. Baltimore St

15 FEB 11 1924 Filed ROBERT H. KRAUTER Clerk

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1924, to Feb 9, 1924.

that I last saw her alive on Feb 9, 1924.

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Second Stage of Pneumonia 4 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. B. Jones M.D.

Feb 10 1924 (Address) 1167 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Feb 12 1924
20 UNDERTAKER Funkhouser & Sickler	ADDRESS 1739 Eager

Cor.--1-12-23—M&T—100 Bks.

83669 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

77 D 83669

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital ST., 20 WARD)

2-FULL NAME Robert H D Inger

(a) RESIDENCE NO. 1917 Fodrick ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John D'Inger

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann A Reed

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Gertrude E Cole
(Address) 1917 Fredrick Ave

Filed FEB 11 1924, 192 ROBERT R. KRAUTER, Registrar

FEB 11 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Duration (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Schaefer, M. D.
(Coroner.)
, 192 (Address) 1701 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 12 1924
20 UNDERTAKER George J Smith	ADDRESS 1582 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Osing

Spec. 1923-741—1500 Bks.

D 83670

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D 83670

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1307 N Saratoga ST. 19 WARD)

2-FULL NAME Mary A. Osing,

(a) RESIDENCE No. 1307 N Saratoga, ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D Osing

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 68; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: John Hauke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Fred L. Osing
(Address): 1307 Saratoga

15 Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1924, to Feb 9.15, 1924, that I last saw h~~e~~r alive on Feb 9, 1924, and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary): Acute Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Watson M. D.

, 19 (Address) 1735 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Feb 12 19 24

20 UNDERTAKER: George J. Smith — ADDRESS: 1532 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16 9176 ~~HEALTH DEPARTMENT—CITY OF BALTIMORE~~ ✓

~~D 83671~~ CERTIFICATE OF DEATH. 100-001 D 83671

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Peters

(a) RESIDENCE NO. 1722 Capri St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
—	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Turner Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

FEB 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924 to Feb 3, 1924.

that I last saw her alive on Feb 3, 1924,

and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Extreme Rickets, L

Acute Pneumonia, primary secondary

acute Pneumonia (duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Extreme Rickets (duration) Life yrs. Child mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) O. Ray. T. Burt M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health, FEB 11 1924

per Wm. E. WOODALL

N. B.—PHYSICIANS, MIDWIVES AND UNDERTAKERS should be careful to see that every question on this certificate is answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83672

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

4 D 83672

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Fisner

(a) Residence No. ~~Unknown~~ 908 McCulloh St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Fisher

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 ? yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer .....

9-BIRTHPLACE (city or town) ? (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country),

14- (Informant) Municipal Hospital Records

(Address) .....

15- Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 4 1924 to February 8 1924, that I last saw h.. er alive on February 8 1924, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma V. Stomach

(Duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Dixon, M. D

2-9-1924 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Laurel Cemetery	Feb. 11, 1924
20-UNDERTAKER,	ADDRESS
Mrs. Chas. B. Jones	172 Eastlands.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D 83673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Claremont Ave., 16 WARD)

2-FULL NAME John Gerhard

(a) RESIDENCE NO. 615 Claremont Av. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Gerhard

6 DATE OF BIRTH (month, day, and year) Feb 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Severson & Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John A Gerhard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Albertine Bluni

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Florence Gerhard

(Address) 615 Claremont Ave

FEB 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 9- 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to February 9 1924, that I last saw him alive on February 8 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus.

10 min.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous Peritonitis - Chronic

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Michel M. D.

19 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL FEB 12 1924

20 UNDERTAKER Geo W Little ADDRESS 2900 EDMONDSON AVE.

N. B.—WRITE PLAINLY, with unfading ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M—1500 Bks.

1691779

D 83674

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-09 83674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Eden

(a) RESIDENCE NO. 224 N. Madison St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 10, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
X	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer H

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Eden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Lingirl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Records

(Address) JOHNS HOPKINS HOSPITAL

Date FEB 1 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924 to Feb 9, 1924.

that I last saw her alive on Feb 9, 1924

and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

Acute Otitis (Media

(duration) ..... yrs. ..... mos 1½ ds.

CONTRIBUTORY (Secondary) Dysentery

(duration) 2 yrs. ..... mos. 9 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) Chas. L. Duval, M. D.

1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Feb. 11 1924

20 UNDERTAKER ADDRESS

Jos. J. Herr & Son 1564 N. Luzerne Ave.

N. B.—WHITE PAPER, WRITE DISTINCTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83675

CERTIFICATE OF DEATH.

38 D 83675

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 N. Bruce ST., 19 WARD)

2-FULL NAME Henry P. Pettigrew

(a) RESIDENCE NO. 319 N. Bruce ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florida Pettigrew

6 DATE OF BIRTH (month, day, and year) Jan 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco worker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Pettigrew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Dont Knows.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Florida Pettigrew
(Address) 319 N Bruce St

15 FEB 11 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1921, to Feb. 8th, 1924, that I last saw him alive on Feb. 8th, 1924, and that death occurred, on the date stated above, at 12:20 A. m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Nephritis & Endocarditis

(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wasserman.

(Signed) James M. Hayes, M. D.

19 (Address) 513 N. Gilmor St,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	2/11 1924
20 UNDERTAKER Samuel D. Hawley	ADDRESS 578 N Eddie

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83676

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 83676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 E. Fort ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest G. George Jr

(a) RESIDENCE NO. 822 E. Fort ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Ernest G. George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Nanna McJohnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ernest G. George

(Address) 822 E. Fort Ave

15 Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Feb 10, 1924, that I last saw h alive on Feb 10, 1924 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(7 Mo. Uterogestation)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell, M. D.

Feb 11, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	2/11/1924

20 UNDERTAKER Wm. J. C. Slemm & the Bentley Co ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83677

CERTIFICATE OF DEATH.

90D 83677

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2624 E. Madison St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine J. Foxwell

(a) Residence No. 2624 E. Madison St., 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles E. Foxwell

6-DATE OF BIRTH (month, day and year) Nov. 21st 1859

7-AGE. 64 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Garey.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Jane Guyon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Elizabeth Bradyhouse

(Address) 2624 E. Madison

15- FEB 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 9th 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24 to Feb 9 19 24

that I last saw h.. alive on Feb 9 19 24

and that death occurred, on the date stated above, at 4.50 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Asthma

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Hughes M. D.

2-11, 19 (Address) 600 N. Wolfe St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cemetery

DATE OF BURIAL. Feb 12th 1924

20-UNDERTAKER, Lilly & Zitz

ADDRESS 4008 Wolfe

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83678 ✓ 129 D 83678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 106 S. Durham St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Meinzinger

(a) Residence No. 106 S. Durham St., 2 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of ~~WIFE~~ Eva E. Meinzinger

6-DATE OF BIRTH (month, day and year) Dec 28th 1854

7-AGE, 69 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Teamster for 3 yrs
(b) General nature of industry, business, or establishment in which employed (or employer) Kimball-Tyler
(c) Name of employer.....

9-BIRTHPLACE (city or town)... Balto. Md.....
(State or Country),

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14- (Informant) John Meinzinger
(Address) 106 S. Durham St.

15- Filed..... 192.....

ROBERT R. KRAUTER, Registrar.

FEB 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1924 to Feb 7 1924

That I last saw h.. alive on Feb 7 1924

and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis.

Hyp. Heart.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Gen. Arteriosclerosis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam.

(Signed) C. E. Hanselman M. D

Feb 8 1924 (Address) 3508 Gough St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	Feb. 12th 1924
20-UNDERTAKER.	ADDRESS
Lilly-Zeiler	403 S. Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83679 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83679

11-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1515 N Dallas St ST., 9 WARD)

2-FULL NAME William O'Brein

(a) RESIDENCE No 1515 N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leotha O'Brein

6 DATE OF BIRTH (month, day, and year) March 12/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Furnace -man
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph O'Brein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Missouri Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Leeotha Williams
(Address) 1515 N. Dallas St.

15 FEB 11 1924 ROBERT R. KRANTZ Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency, following Influenza.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. K. Voiers M. D.
(Coroner)

Feb 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Feb 11 1924
20 UNDERTAKER Wm. Gerth Hoffa	ADDRESS 406 W. Cary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Morris 2 McCoy.

D 83680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 112 S. Mount ST., 19 WARD)

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McCoy, Morris Lee

(a) RESIDENCE NO. 1848 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred new born yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Feb. 6, 1924

7 AGE: Years | Months | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Bradley McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Anna Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mathews Cty, Virginia

14 Informant: Bradley McCoy

(Address): 1848 W Fayette

15 Filed FEB 11 1924, ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924 to Feb. 10, 1924

that I last saw h[illegible]live on Feb. 9, 1924

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Atelectasis — general under-development (born birth)

since birth (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Organism fever 2 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) A. A. Sprogis, M. D.

, 19 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 2/11- 1924

20 UNDERTAKER: Wm. J. Tschudy & Son — ADDRESS: north & Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. DATA must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D 83681

1-PLACE OF DEATH

City of BALTIMORE: (No. 2633 St. Paul St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Ann Martin

(Residence in Baltimore: No. 2633 St. Paul St.; yrs. 20 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: May 14 1846 (Month) (Day) (Year)

7-AGE: 77 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Michael Bulack

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Alice A. Bulack

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Margaret E. Jones

(Address) 2633 St. Paul St

15- Filed FEB 11 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 9, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries due to a fall

Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dwight J. Russell M. D. (Coroner.)

Feb 10 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem. DATE OF BURIAL, Feb 12 1924

20-UNDERTAKER, Wm Tuckers Sons ADDRESS North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Anna Lurz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83682

CERTIFICATE OF DEATH.

14-001 ✓

D 83682

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 N. West St ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Lurz

(Residence in Baltimore: No. 1827 N. West St. St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, March 18, 1871 (Month) (Day) (Year)

7-AGE, 52 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Thomas Lurz

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Mary Heine

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lurz

(Address) 1827 N. Washington St.

Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 10 1923, to Feb 8 1924, that I saw h alive on Feb 8 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 13 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) 1 yrs. 6 mos. ....ds.

(Signed) Jacob Fischer M. D.

Feb 11, 1924 (Address) 1823 N. West St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL, 2/13, 1924

20-UNDERTAKER Chas F. Wood & Son

ADDRESS 1811 W. Mt Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83683

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1455 N. Carrick ST., 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. E. Day

(a) RESIDENCE NO. 1455 N. Carrick ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colrd	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1924 guess

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry Day
(Address) 1455 N. Carrick

15 FEB 11 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

(Address) 2802 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 11 1924
20 UNDERTAKER	ADDRESS
Thomas E. Wright	1647 Mar

REGISTRAR SHOULD BE CAREFULLY SUPPLIED. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIAN'S and REGISTRAR'S should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83684

D 83684

CERTIFICATE OF DEATH.

31

15

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Mount St. ST., WARD)

2-FULL NAME Lavinia Phillips.

(a) RESIDENCE NO. 1501 N. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	XXXX	XXX	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 010

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Charlotte Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph E. Phillips

(Address) 1501 Mount St.

15 Filed FEB 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1924.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 8 1924, 19..., to Feb 8 1924, 19...,

that I last saw her alive on Feb. 7 1924, 19...,

and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical evidence

(Signed) Charles G. Clark, M. D.

Feb 10, 1924 (Address) 1306 W. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Port	Feb 14 1924
20 UNDERTAKER	ADDRESS
Thomas E. Wright	1342 W. Pratt St

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful, when certifying to CAUSE OF DEATH, that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83685

CERTIFICATE OF DEATH.

100-001 ✓ D 83685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana Stepney

(a) RESIDENCE No. 1020 Wheatcoat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Municipal Hospital Records

15 Filed FEB 1 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 9 1924

17

I HEREBY CERTIFY, That I attended deceased from 12 - 14, 1923, to 2 - 9, 1924, that I last saw her alive on 2 - 9, 1924 and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Howe, M. D.

2-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bethel Cemetery

DATE OF BURIAL Feb 4 1924

20 UNDERTAKER Bennett & Wright

ADDRESS 1600 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS INFORMATION should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILM TYAE

Spec.—1-10-21—MAT—1500 Blks.

D 83686

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D 83686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Edmondson Av ST., 19 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret R. Miller

(a) RESIDENCE No. 1711 Edmondson, Av ST., ... WARD 8 4m

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 1857

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Employee 086

(b) General nature of industry, business, or establishment in which employed (or employer): Medical Department

(c) Name of employer: Sharp & Dohme

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Matthew W. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebekah Oster

13 BIRTHPLACE OF MOTHER (city or town) Penna. (State or country)

14 Informant J. Theo Oster

(Address) 2242 Linden Ave

15 Filed FEB 11 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1924, to Feb 10, 1924, that I last saw h alive on Feb 9, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Tr bronchitis

(duration) yrs. mos. 3- ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H Roland Keech, M. D.

, 19 (Address) 305 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Feby 13 1924

20 UNDERTAKER: John B Spence — ADDRESS: 1326 N Carrollton Av

U. S.—WHITE PLAINLY, WITH INDELIBLE INK. THIS DATA IS FOR STATISTICAL RECORDS ONLY. EACH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DARKE

D 83687 HEALTH DEPARTMENT—CITY OF BALTIMORE 159-D 83687

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 409½ Paca St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Maryland

(Residence in Baltimore: No. 409½ Paca St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH: Feb (Month) 8 (Day) 1924 (Year)

7-AGE: .....yrs.....mos. 1/3 ds. If LESS than 1 day, 8 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 600

9-BIRTHPLACE, (State or Country): Balt City

PARENTS.

10-NAME OF FATHER, William Maryland

11-BIRTHPLACE OF FATHER, (State or Country), Balt City

12-MAIDEN NAME OF MOTHER, Elizabeth Brown

13-BIRTHPLACE OF MOTHER, (State or Country), Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Maryland

(Address) 409½ Paca St.

15- Filed FEB 11 1924 Albert F. Hafferd, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 6 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease probably Foramen Ovale

Immediate Efficiency

(Duration).....yrs.....mos. 6 Hrs.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James H. Kerr M. D. (Coroner.)

Feb 8 1924 (Address) 701 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Iron Cem.	2-12, 1924

20-UNDERTAKER	ADDRESS
Brown & Freeland	114 N. Schroeder St.

FEB 11 1924

Burial Permit Clerk.

FEB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83688

CERTIFICATE OF DEATH.

80

D 83688

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Clarkson ST.: 23. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Everett Lee Gerhard.

(a) RESIDENCE. No. 1403 Clarkson ST., 23. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May, 23, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8,	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER George Gerhard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marguerite Knipp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Marguerite Gerhard.
(Address) 1403 Clarkson St.

15 Filed ..... 19 Robert P. Harrison, Registrar

FEB 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9— 1924

17

I HEREBY CERTIFY, That I attended deceased from July 6th, 1924, to July 9—, 1924, that I last saw h[illegible] alive on July 9— 1924, and that death occurred, on the date stated above, at 1 45 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) H. Hunter M. D.

. 19 (Address) 1300 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem.	Feb. 12, 1924

20 UNDERTAKER	ADDRESS
A. Howard Evans	1428 N. Charles

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr 29 Chart
120 N. Female

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83689

CERTIFICATE OF DEATH.

1924 D 83689

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Albion Hotel Cathedral (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Dallas Wyshaun

(a) Residence No. Albion Hotel (Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Wyshaun

6-DATE OF BIRTH (month, day and year) July 28-1859

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER John Wood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Isabel Sewell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14-Informant Geo. F. Wyshaun

(Address) Albion Hotel

15-Filed 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2.10.24

17- I HEREBY CERTIFY, That I attended deceased from Feb 5 1924 to Feb 10 1924, that I last saw h. a. alive on Feb 10th 1924 and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Johnston, M. D.

, 19 (Address) 211 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Belmont	2/12, 1924
20-UNDERTAKER W. S. Cook	ADDRESS 502 E. Nash

FEB 11 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83690

CERTIFICATE OF DEATH. 118-002

D 83690

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. ST., ... WARD) 12

2-FULL NAME Miss Theresa Widekind

(a) RESIDENCE NO. 2109 St. Paul ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W.

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Gustave A Widekind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria T Hagerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella M Widekind (Address) 2109 St Paul St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

FEB 11 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-8-24 19..... to 2-10, 1924.

that I last saw her alive on 2-10, 1924

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Adhesion following acute

appendicitis op. - 5 years ago.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxemia; cardiac failure

(duration) ..... yrs. ..... mos. 18 hrs. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 2-9-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Thos A Shampteller, M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL Feb 12 1924

20 UNDERTAKER W. W. Cork — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—EVERY LINE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr F. L. O. Helm 2727 N. Monroe

D 83691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83691

Registered No.....

1-PLACE OF DEATH 1810 Madison Ave

City of BALTIMORE: (No. ..... St., ... Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Albert Blades

(a) Residence No. 1810 Madison Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Fannie L. Blades

6-DATE OF BIRTH (month, day and year) Apr. 14, 1854

7-AGE. 69 yrs. 9 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Armstrong Cater

9-BIRTHPLACE (city or town) (State or Country) St. Michaels Md.

PARENTS.

10-NAME OF FATHER William P. Blades

11-BIRTHPLACE OF FATHER (city or town) (State or Country) St. Michaels Md.

12-MAIDEN NAME OF MOTHER Caroline Seth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14-

(Informant) Fannie L. Blades

(Address) 1810 Madison Ave

15-

FILED FEB 11 1924 By Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 10. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 26 1922 to Feb 10 1924

that I last saw him alive on Feb 10 1924

and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (Duration) 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. L. O. Helm M. D.

2/11/24 (Address) 1717 N. North Ave

State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore — DATE OF BURIAL. Feb 12 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E. North Ave

*Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Mooresey 3632 Roland Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83692

D 83692

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Homewood Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 12

2-FULL NAME Salvador Charles Romano

(a) RESIDENCE No. 2446 Oak Street ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Divorced

5a If married, widowed or divorced HUSBAND of (or) WIFE of Marie Romano

6 DATE OF BIRTH (month, day, and year) March 3. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Paul Romano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rozetta Moscati
(Address) 1431- E 29th Street

15 Filed ..... 192 Robert P. Harrison, Registrar

FEB 11 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cabouler disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. J. Mooresey, M. D. (Coroner.)

Feb 16, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., 1 ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? 2446 Oak Street

Former or usual residence 2446 Oak Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Feb 12 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Madison

DIRECTIONS TO PHYSICIAN. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83693

REGISTERED NO. 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen. Hospital ST., WARD

2-FULL NAME William E. Noakes

(a) RESIDENCE NO. 1127 St. Mount ST., WARD 16

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Noakes

6 DATE OF BIRTH (month, day, and year) Sept 23 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	4	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wagon Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Regal Laundry

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mrs. Noakes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Rhoades

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E Noakes
(Address) 1127 N. Mount

15 Filed FEB 11 1924, 192 Robert P. Harris, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushing injuries to chest

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) yrs. mos. ds.

(Signed) J. E. T. Hennessy M. D. (Coroner.)

Feb. 11, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1127 N. Mount

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 2/13 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E 10th

Burial Permit

Information should be clearly supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D Riley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83694 — 90 — D 83694

CERTIFICATE OF DEATH

1-PLACE OF DEATH Madison Ave & Druid Hill Gate Entrance Car Barn Limited or on way to mercy Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No.) ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Edward Deweese 15

(a) RESIDENCE NO. 1011 Whitelock ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male — 4 COLOR OR RACE White — 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) July - 23 - 859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer United Railway Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Garrett Deweese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ellen Carson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rhode Island

14 Informant Melinda C. Deweese
(Address) 1011 Whitelock St

15 Filed ..... 192 .... Robert P. Harrison, Registrar

FEB 1 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio. dis. heart.

Some years (duration) chronic endocarditis

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) [illegible], M. D.
1/31, 192 4 (Address) (Coroner.) 16 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Woods — DATE OF BURIAL 2/13 192 4

20 UNDERTAKER William Cook — ADDRESS 502 E North Ave

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 83695

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 83695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Marion Cobb

(a) RESIDENCE NO. 1407 N. Lexington ST., WARD

(Usual place of abode) Aged Mens Home (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1837

7 AGE: Years 87 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER Hamilton Cobb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Hosp Hospital Records (Address)

FEB 11 1924 Filed, 19 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1924, to Feb 11, 1924, that I last saw him alive on Feb 11, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of Right Femur

WP

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Aged Mens Home 1407 N. Lexington St

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? X ray & Clinical Findings

(Signed) David R. Nuremore, M. D.

2/11, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Feb 14 1924

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Hollins

R.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it ma TION is very important. See instructions on ba E should be stated EXACTLY. PHYSICIANS should write it may be properly classified. Exact statement of OCCUPA- on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83696 ✓ D 83696

CERTIFICATE OF DEATH.

3

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4205 Evergreen Ave ST.; WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry H. Eburgh

(Residence in Baltimore: No. 4205 Evergreen Ave St.; 40 yrs., 9 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 4, 1884
(Month) (Day) (Year)

7-AGE, 40 yrs. 9 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electric Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Colgate Co.

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry H. Eburgh

11-BIRTHPLACE OF FATHER (State or Country), York Pa.

12-MAIDEN NAME OF MOTHER, Catherine Rink

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Henry Eburgh

(Address) 4205 Evergreen

15- Filed ..... 191.....
Robert P. Harrison,
Registrar.
Burial Permit Clerk

B T 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 9, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1917, to Feb. 9 1924, that I saw h— alive on Feb. 7 1924, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Influenza

(b) Pneumonia Influenza

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. ds.

(Signed) H. J. Boyer M. D.

2-9, 1924. (Address) 801 E Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 12, 1924

20-UNDERTAKER M Kelly & Son — ADDRESS 1612 W North

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83697

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Joseph Dunbach

(a) RESIDENCE NO. 2848 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dunbach.

6 DATE OF BIRTH (month, day, and year) Feb. 25, 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84 yrs.	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Horticulturist
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. ~~Wm.~~ Agnes Dillon
(Address) 2728 E. Baltimore St.

15 Filed FEB 1 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of leg

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 2 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Feb. 11, 192 4 (Address) 28 Courtland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral Cemetery	2/13, 1924

20 UNDERTAKER John A. Moran ADDRESS 3001 E. Baltimore St.

MEDICAL EXAMINER SHOULD BE CAREFUL. AGE SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 83698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83698

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1506 Riverside Ave. (WARD)

2-FULL NAME John Batchelor

(a) RESIDENCE NO. 1506 Riverside Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of the late Minnie Kunze Batchelor

6 DATE OF BIRTH (month, day, and year) June 25. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Batchelor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mont. Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wm. Burns (daughter)

(Address) 150 a Riverside ave

15 Filed Robert P. Harrison, Registrar

B 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from 11. 1. 23, 19.... to 2. 10. 24. 19....

that I last saw him alive on 2. 10. 24, 19....

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Auricular Fibrillation

Chronic nephritis

(duration) Yrs. Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Edward Morris, M. D.

2, 10., 19 24 (Address) 107 E West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Feb. 13 1924

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light St

N.B.—WRITE PLAINLY, WITH INK. ALL ITEMS SHOULD BE STATED EXACTLY. PHYSICIAN'S AGE should be carefully supplied. DATE mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83699

CERTIFICATE OF DEATH.

45 D 83699

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3142 Strickland St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma Dudderar

(a) Residence No. 3142 Strickland St., ... Ward 10

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 53 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (City or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country), Unknown

14- (Informant) Mrs. Thomas Jenkins

(Address) 3142 Strickland

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

EB 11 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 8 - 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 ..... 19 24 to Feb 8 ..... 19 24

that I last saw h.. alive on Feb 7 ..... 19 24

and that death occurred, on the date stated above, at 9-28 ..... m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(Duration) Minutes ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis ?

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert C Bartlett M. D.

Feb 10, 192 4 (Address) 202 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Guilford Md — DATE OF BURIAL. 2-12-1924

20-UNDERTAKER. David Easton — ADDRESS 916 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 83700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83700

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 567 Oxford St., ... Ward)

2-FULL NAME Ethel Evans

(If death occurred in a hospital or Institution, give its NAME Instead of street and number.)

(a) Residence No. 567 Oxford St., ... Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If not resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1891

7-AGE. 33 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country) Balto City

PARENTS

10-NAME OF FATHER Henry B Evans

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Butler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

11-(Informant) T H Hill

(Address) 567 Oxford St

13-Filed FEB 11 1924, 192..

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 9. 24

17-I HEREBY CERTIFY, That I attended deceased from Nov 15, 1923 to Feb 9, 1924

that I last saw h.. alive on Feb 9, 1924

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas H Hunnicutt M. D

Feb 10, 1924 (Address) 3002 Harrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 2-12-1924

20-UNDERTAKER Sam'l Eastis — ADDRESS Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83701

CERTIFICATE OF DEATH.

74-001

Registered No.....

D 83701

1-PLACE OF DEATH

City of BALTIMORE: (No. 4006 Pennhurst Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Smith

(a) Residence No. 4006 Penhurst ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) Aug 16 1849

7-AGE, 74 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hartford Conn

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Ellen M. Jenkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Mrs. Lillian Johnson

(Address) 4006 Penhurst Ave

15- FILED FEB 11 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 19 20 to Feb. 11 19 24

that I last saw h alive on Feb 10 19 24

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 20 Min ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

Cerebral apoplexy - 1920

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Brumbach M. D.

2-11 19 24 (Address) 1536 Pratt

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Hartford Conn DATE OF BURIAL Feb 11 19 24

20-UNDERTAKER. W. Jackson Sons ADDRESS North Pa

All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83702

CERTIFICATE OF DEATH.

74-001 D 83702

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 So. Bond ST., WARD)

2-FULL NAME Joseph Zycha

(a) RESIDENCE No. 838 So. Bond St ST., 15 WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 71	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

040

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant M. F. Sadowski
(Address) 705 So. Anne St.

15 Filed FEB 1 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. ..... mos. ..... ds.

(Signed) Wm. J. Scarborough, M. D.
(Coroner.)
Feb 11, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Feb 12, 1924

20 UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Anne

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1509 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83703

CERTIFICATE OF DEATH.

41 D 83708

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Md. Gen'l. Hospital.

CITY OF BALTIMORE: (No.) Linden Ave & Madison St., WARD) 9

2-FULL NAME Mrs. Barbara Stackloff.

(a) RESIDENCE NO. 2707 Fenwick Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward G. Stackloff.

6 DATE OF BIRTH (month, day, and year) 4/12/1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hsw.

(b) General nature of industry, business, or establishment in which employed (or employer) ——— 037

(c) Name of employer ———

9 BIRTHPLACE (city or town) Baltimore. (State or country)

PARENTS

10 NAME OF FATHER Frank Beusterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Kathryn Pennell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Edward G. Stackloff

(Address) 2707 Fenwick Ave.

15 FEB 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1924, to Feb 10 1924, that I last saw her alive on Feb 10 1924, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

(Erysipelas) 8 days

Influenza 2 Months (8 days)

Ch. Nephritis 1 yr

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Feb 7th 10th

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 14 1924

20 UNDERTAKER George J. Pratt ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Rupp)

D 83704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83704

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 807 N. Belnord St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Andrew T. Ruff.

(a) Residence No. 807 N. Belnord St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene F. Ruff.

6-DATE OF BIRTH (month, day and year) March 11 1862

7-AGE. 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer). 615 W. Lexington

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Carroll County

PARENTS.

10-NAME OF FATHER. John Ruff.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Carroll County.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Carroll County.

14-

(Informant) Mrs. Eugene Ruff.

(Address) 807 N. Belnord Ave

15-Filed FEB 1 2 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-11-24

17- I HEREBY CERTIFY, That I attended deceased from 2-10 1924 to 2-11 1924

that I last saw him alive on 2-11 1924

and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Hemorrhage, Mitral Stenosis (Duration) yrs. mos. 2 dys.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred Rupp M. D.

11 1924 (Address) 806 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westminster Cemetery. DATE OF BURIAL. Feb. 14, 1924

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1235 Harford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83705

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2108 Orleans ST., 6 WARD)

2-FULL NAME Fannie Jonas

(a) RESIDENCE NO. 2108 Orleans ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Jonas

6 DATE OF BIRTH (month, day, and year) Apr. 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Solomon Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Samuel Jonas

(Address) 2108 Orleans st.

15 Filed FEB 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 10, 1924, that I last saw h alive on Feb 9, 1924, and that death occurred, on the date stated above, at 9-15 a. m.

The CAUSE OF DEATH* was as follows:

Uremia (Primary)

Chronic Nephritis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. mos. 10. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Mayo M. D.

10/2 1924 (Address) 2038 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Feb 12, 24
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83706

CERTIFICATE OF DEATH.

101-001 D 83706

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 822 Herman's Ct. ST., 10 WARD)

2-FULL NAME Daniel Powell

(a) RESIDENCE No 822 Herman's Ct. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Powell

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sparks, Md.

PARENTS

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. R. A. Elliott
(Address) 1725 Ashland Ave

15 Filed FEB 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds. 8

CONTRIBUTORY (Secondary) Alcoholism & Exposure

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Watts, M. D.
(Coroner.)

Feb 11/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sparks Md. DATE OF BURIAL Feb 12 1924

20 UNDERTAKER Mrs R A. Elliott ADDRESS 1725 Ashland Ave

D 83707

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D 83707

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 3517 Fairview Ave, ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Lee Denny

(Residence in Baltimore: No. 3517 Fairview Ave | 50 St.; 67 yrs. 5 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Sept 4, 1856 (Month) (Day) (Year)

7-AGE: 67 yrs. 5 mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Dealer in
(b) General nature of industry, business, or establishment in which employed (or employer): Wall Paper

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: William Denny

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Lee

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia A. Denny (wife)

(Address) 3517 Fairview Ave

15- Filed FEB 1 2 1924, 191 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feby. 11, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 11, 1924, to, Feby 11 1924, that I saw h[illegible] alive on Feby 11 1924, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism Detached

(Duration) ..... yrs ..... mos ..... ds.

Contributory (SECONDARY) Hypertension Myocarditis

(Duration) ..... yrs ..... mos ..... ds.

(Signed) Edward A. Thompson M. D.

2-11 1924 [Address] 516 Eastern

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Feb 13, 1924

20-UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83708

CERTIFICATE OF DEATH.

161-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 E. Monford Ave ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Rychwalska

(a) RESIDENCE. No. 817 S. Monford ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7. 24

7 AGE — Years | Months | Days: 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Rychwolski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Kaszek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Joseph Rychwolski
(Address) 817 Monford

15 Filed FEB 1 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 7. 1924. to Feb 10 1924

that I last saw h— alive on Feb 9 1924

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rychwalski, M. D.

M. C. 19 (Address) 501 S Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Feb 12 1924

20 UNDERTAKER Stephen L. Fralkowski — ADDRESS 1000 N Kenwood Ave

INFORMATION should be carefully supplied. AGE—should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83709

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2722 Elliott St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas P. Mullaney

(a) Residence No. 2230 Hudson St. St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 28 1881

7-AGE. 42 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Caulker

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Bldg.

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER Thomas P Mullaney

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto

12-MAIDEN NAME OF MOTHER Elizabeth Bock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto

11- (Informant) Martin Mullaney

(Address) 2904 Dillon St

15- FEB 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 1921 to Feb 11 1924

that I last saw h— alive on Feb 10 1924

and that death occurred, on the date stated above, at 120 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? — Uncertain

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Clinical

(Signed) M J McAvoy M. D

19 (Address) 839 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cem — DATE OF BURIAL. Feb 14 1924

20-UNDERTAKER. Stephen J Kulikowski — ADDRESS 839 S Ellwood Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83710

16 94 10 83710

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Johns Hopkins Hospital (15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST.,

2-FULL NAME James Parren

(a) RESIDENCE NO. 1342 N. Stricker St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Smuter Parren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Shuger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) JOHNS HOPKINS HOSPITAL Records

15 Filed FEB 12 1924 ROBERT H. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1924 to Feb 8 1924.

that I last saw h alive on Feb 8 1924

and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Cyst of Neck (Infected)

Acute Pneumonia (Primary)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pneumococcus Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas R Bagg M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Feb 12 1924

20 UNDERTAKER S. E. Brown & Son

ADDRESS 1818 W Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83711

CERTIFICATE OF DEATH.

31 D 83711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 Stump St. ward 22) REGISTERED NO.

2-FULL NAME Lula Lee

(a) RESIDENCE NO. 505 Stump St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Lee

6 DATE OF BIRTH (month, day, and year) ——— 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 321

(c) Name of employer

9 BIRTHPLACE (city or town) Fort Valley
(State or country) Georgia

PARENTS

10 NAME OF FATHER Pat Jefferson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Mandy ———

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Georgia

14 Informant Edward Lee
(Address) 505 Stump st

15 Filed FEB 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10 1924

17

I HEREBY CERTIFY, That I attended deceased from June, 1, 1922, to 2/10, 1924, that I last saw her alive on 2/10, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum pos.

(Signed) Dan Franklin, M. D.

2/11/1924 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	Feb 13 1924
20 UNDERTAKER	ADDRESS
I. L. Brown & Son	1016 W Monty

N. B.—MARRIAGE LICENSES WITH UNFAVORABLE RECORDS. EACH ITEM of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 ✓ D 83712

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Briscoe ST. 21 WARD)

2-FULL NAME Margaret A. Vogel

(a) RESIDENCE No. 1209 Briscoe ST., WARD W1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis A. Vogel

6 DATE OF BIRTH (month, day, and year): Oct. 8 1867

7 AGE — Years: 57 — Months: — — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer): 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Louis A. Vogel (Address) 1209 Briscoe St

15 FEB 1 2 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 11. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb 11, 1924

that I last saw h alive on Feb 10, 1924

and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. B. Campbell, M. D.

Feb 11, 1924 (Address) 1604 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb 13 1924

20 UNDERTAKER: Wm. Wm. John H. Teufel & Son — ADDRESS: 801 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA given on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83713

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5224 Dennison Ave (Ward) 27

2-FULL NAME Alice Wilkinson

(a) RESIDENCE. (Usual place of abode) No. 5224 Dennison St., Ward.

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Dec. 25-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Morris Royster

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Josie Wilkinson (Address) 5224 Dennison ave

15 FEB 12 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb-2, 1924, to Feb-9, 1924, that I last saw h.r alive on Feb-8, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Tabernacle Heart-Trouble (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of Feb 9.

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) W. D. Wells, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL Feb. 12 24

20 UNDERTAKER Barnett Hemsley

ADDRESS 578 N Eddley

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83714

CERTIFICATE OF DEATH. 14-001 D 83714

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Schwartzhaupt

(a) RESIDENCE NO. 2018 Orleans ST., ... WARD 6

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 2 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Fred. Schwartzhaupt

6 DATE OF BIRTH (month, day, and year) Dec 5/72

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerical Work
(b) General nature of industry, business, or establishment in which employed (or employer) Rag Business
(c) Name of employer Francis Bohager

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Sam'l Bohager

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Rose ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Margie Aumiller
(Address) 2022 Orleans St

15 Date received FEB 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage (Rt. Lateral Ventricle)
(Autopsy At Hospital)
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis- Chr. Nephritis (duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Potter, M. D.
(Coroner.)

Feb 11/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 2/13 1924

20 UNDERTAKER Philip Herring

ADDRESS 2014 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.R.S.—400 Pks.

D 83715 MD

D 83715 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 112 O.H. J. H. Galter Coroner

1-PLACE OF DEATH 1817 East 33rd St. Registered No. 12/24

City of BALTIMORE: (No. ~~2910 Guilford Ave~~ St., 12 Ward 5 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan P. Pitcher

(a) Residence No. 2910 Guilford Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B. Eaton

6-DATE OF BIRTH (month, day and year) Sept 4 1883

7-AGE. 40 yrs. 5 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Atty at Law

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country) Md

PARENTS.

10-NAME OF FATHER Philip P. Pitcher

11-BIRTHPLACE OF FATHER (city or town) A. A. Co
(State or Country) Md.

12-MAIDEN NAME OF MOTHER Mary A. Pumphrey

13-BIRTHPLACE OF MOTHER (city or town) A. A. Co
(State or Country) Md.

14- (Informant) Emma E. Ryan
(Address) 552 N. Bakers St.

15- FEB 12 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 11/24

17- I HEREBY CERTIFY, That I attended deceased from Feby 10 1924 to Feby 11 1924 that I last saw him alive on Feby 10 1924 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation Acute (Duration) 0 yrs. 0 mos. 6 ds

CONTRIBUTORY (Secondary) Acute Indigestion (Duration) 0 yrs. 0 mos. 6 ds

18-Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Hamner M. D

2/12 1924 (Address) 700 N. Howard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL. Feby. 14 1924

20-UNDERTAKER. John O'Mitchell ADDRESS 1201 N. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83716

CERTIFICATE OF DEATH.

11-002 D 83716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1910 W Fairmount Ave ST.) 10 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline E Morris

(a) RESIDENCE. NO. 1910 W Fairmount Ave ST. WARD. 10

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J Morris

6 DATE OF BIRTH (month, day, and year) Sept 15, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67.	4.	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hiram Albaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Caroline Deeny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dr JH Hoffmann

(Address) 1802 W Saratoga

15 Filed FEB 1 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 4, 1924, to Feby 11, 1924, that I last saw h[illegible] alive on Feby 10, 1924, and that death occurred, on the date stated above, at 12.35 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) ..... yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. O'Neill, M. D.

2/11, 1924 (Address) 108 N Bethune Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb. 13, 1924

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Saratoga

THIS IS A LEGAL DOCUMENT AND SHOULD BE CAREFULLY PREPARED. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 83717

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2601 N. Charles St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clementine G. Bond

(a) Residence No. 2601 N. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John W. Bond

6-DATE OF BIRTH (month, day and year) Jany 28. 1853

7-AGE. 71 yrs. — mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto Md
(State or Country),

PARENTS.

10-NAME OF FATHER Thomdyke Chase

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country).

12-MAIDEN NAME OF MOTHER, Clementine Darnell

13-BIRTHPLACE OF MOTHER (city or town)..... Md.
(State or Country).

14- (Informant) Jane Bond Haynes

(Address) East orange N. J.

15-

Filed ..... 192.... Registrar.

FEB 12 1924 ROBERT R. KRAUTH
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Febry 10/24

17- I HEREBY CERTIFY, That I attended deceased from Febry 7 19 24 to Febry 10 19 24

that I last saw her alive on Febry 10 19 24

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan F. Stillman, M. D

, 19 (Address) 6 E. Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount DATE OF BURIAL. Feb 12, 1924

20-UNDERTAKER, ADDRESS

John Ortwein & Son 1201 W. Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83718

D 83718

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 - N. 1st. ST.: 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Walter McCracken

(a) RESIDENCE. No. 101 - N. 1st ST., 25 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 0 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara A McCracken

6 DATE OF BIRTH (month, day, and year) Feb 25 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James McCracken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Shore Md

12 MAIDEN NAME OF MOTHER Ricca Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Shore Md.

14 Informant Clara A. McCracken
(Address) 101 First st. Brooklyn City

15 FEB 1 21924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6 1923, to Feb. 10, 1924, that I last saw him alive on Feb. 10, 1924, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Myocardiitis - acute.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William H. Lee M. D.

Feb 10 1924 (Address) 816 - Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 13th 1924
20 UNDERTAKER	ADDRESS 1039
E. Schloneger & Son	Hanover

Mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-00 D 83719

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balto. Gen'l Hospital

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Anthony Mudra-

(a) RESIDENCE No. 509 N Chapel St ST., ... WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	48	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Slovakia-

PARENTS

10 NAME OF FATHER John Mudra

11 BIRTHPLACE OF FATHER (city or town) (State or country) Slovakia

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Slovakia

14 Informant Mrs G Businsky

(Address) 507 N Chapel St

15 FEB 12 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 10, 1924, that I last saw him alive on Feb 10, 1924 and that death occurred, on the date stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Toxaemia from stasis due to dilatation of duodenum & Pyloric Ulcer.

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal Intussception

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb 4/24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Findings

(Signed) John A O'Donnell, M. D.

, 19 (Address) 4704 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Lyndale Cemetery	Feb 13 1924
20 UNDERTAKER Frank Broadbent	ADDRESS 1906 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 83720

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Mount ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Esther Kellert

(a) RESIDENCE NO. 810 Asquith ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellis Kellert

6 DATE OF BIRTH (month, day, and year) 1895 - Jan 17

7 AGE Years 29 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Sandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah Hoffman (Deceased)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ellis Kellert (Address) 810 Asquith St.

15 Filed FEB 7 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/IV 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1924, to Feb. 12, 1924.

that I last saw h in alive on Feb. 12, 1924

and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows: Mitral Stenosis & Insufficiency

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. A. Sussman, M. D.

2/IV. 1924 (Address) Colonial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrem Herring Lee

DATE OF BURIAL 2/7 1924

20 UNDERTAKER Jack Lurk 1439 E Balto St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

Botevetsky

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83721

CERTIFICATE OF DEATH.

90 ✓ D 83721

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Hebrew Aneurohde Home St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Botevetsky

(a) Residence No. 121 N Chester St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M
4-COLOR OR RACE: W
5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Old age
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-(Informant): Jack Lewis
(Address): 1439 E Baltimore

15-Filed FEB 12 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 2-10-24

17- I HEREBY CERTIFY, That I attended deceased from 1/16, 19.24, to 2/10, 19.24
that I last saw him alive on 2/10 19.24
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. Weinberg M. D.
2/11, 1924 (Address) 1826 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 2-12, 1924

20-UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

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should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83722

100-001 D 83722

17

1-PLACE OF DEATH D 83722 Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St.,..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Lee

(a) Residence No. 1128 Pennsylvania St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1868

7-AGE. 55 yrs. ..... mos. ..... ds. If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Armstead Lee

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Sarah Castman

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Virginia

14- Municipal Hospital Records (Informant).....

(Address)..... JOHNS

FEB 7 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

116

29

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 4 1923 to February 9 1924 that I last saw him alive on February 8 1924 and that death occurred, on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Varicose ulcer of knee.

(Duration) 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton, M. D.

2-11 1924 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
HOPKINS HOSPITAL	....., 19....

20-UNDERTAKER.	ADDRESS
Commissioner Health.	FEB 12 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

2005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 83723

CERTIFICATE OF DEATH.

44 D 83723

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Saint Agnes Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry John Loos

(a) Residence No. 524 North Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE: Mary M. Loos

6-DATE OF BIRTH (month, day and year): Mar 4th 1860

7-AGE: 63 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Proprietor

(c) Name of employer: Self

9-BIRTHPLACE (city or town) (State or Country): Deer Md

PARENTS.

10-NAME OF FATHER: Henry Loos

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dorothy Deamer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-INFORMANT: Mrs. H. H. Loos

(Address): Bay City Texas

15- FEB 12 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 11/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 7 1924 to Feb 11 1924

that I last saw him alive on Feb 11 1924

and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Operation:- antegast- gastro-enterostomy)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2-9-24

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D

19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON-PARK Cemetery

DATE OF BURIAL: Feb 14 19 24

20-UNDERTAKER: H. H. Poulton

ADDRESS: Lanvale & Saratoga

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83724

CERTIFICATE OF DEATH.

90 D 83724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 610 Hyson ST., [illegible] WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian S Wagner

(a) RESIDENCE No. 610 Hyson ST., [illegible] WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Walter Wagner

6 DATE OF BIRTH (month, day, and year) [illegible] 1904

7 AGE Years 19 Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas Pattey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cassie [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant [illegible] Pattey

(Address) [illegible]

15 Filed FEB 12 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924 to Feb 8, 1924.

that I last saw h[illegible] alive on Feb 8, 1924;

and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? ...

(Signed) John A. Schumann, M. D.

..., 19.. (Address) 1142 W Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Greenmount Cem

DATE OF BURIAL 2/12 1924

20 UNDERTAKER [illegible] Adams

ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

Brace

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83725

CERTIFICATE OF DEATH.

100-001

D 83725

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 190 N. Bond ST. 7 W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Domenic Brace

(Residence in Baltimore: No. 190 N. Bond St.; 2 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Samuel

11-BIRTHPLACE OF FATHER (State or Country) Italy

12-MAIDEN NAME OF MOTHER Capuano

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph Brace

(Address) 190 N. Bond St.

FEB 12 1924. Filed ..... ROBERT R. KRAUTER... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 11 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924, to Feb. 11, 1924, that I saw h[im] alive on Feb. 10, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene L. Pearson M. D.

2.11.24, 191... (Address) Tow Hills

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Lincoln Cem

DATE OF BURIAL, 2.13., 1924

20-UNDERTAKER L. J. Lakey Sons

ADDRESS 318 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83726 — 31 — D 83726

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N. Streeper ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Wolf

(a) RESIDENCE NO. 515 N. Streeper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 7 mos. 6 ds. How long in U. S. if of foreign birth? 37 yrs. 7 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F — 4 COLOR OR RACE W — 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of Industry, business, or establishment in which employed (or employer) 1084

(c) Name of employer Wise Bros.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Shaffuch.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) U.S.

14 Informant (Address) Sister. 515 N. Streeper St

15 Filed FEB 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1923, to Feb. 9, 1924, that I last saw h[illegible] alive on Feb. 9, 1924, and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum positive

(Signed) L. C. Dobbal, M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL Feb. 13 1924

20 UNDERTAKER Lilly and Zeiler — ADDRESS 403 N. Mon[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83727

CERTIFICATE OF DEATH

9 X/22-001

D 83727

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Winkler

(a) RESIDENCE NO. North Ave. Road Via Eastern Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Ice House.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Winkler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John B. Winkler (Nephew) (Address) 3504 Fleet St.

15 Filed FEB 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1924, to Feb. 9, 1924, that I last saw him alive on Feb. 9, 1924, and that death occurred, on the date stated above, at 1.45 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver. alcoholic

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. J. Fischbach Jr. M. D.

, 19 (Address) 806 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Feb 13 1924

20 UNDERTAKER Tully & Zirkus ADDRESS 403 S. Mo Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83728

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 S. Third St. ST., 76 WARD) No

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Clements

(a) RESIDENCE NO. 907 S. Third St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Clements.

6 DATE OF BIRTH (month, day, and year) March 28-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 10

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Enamel Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Clements.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Cassie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mary E. Clement. 907 S. Third St.

15 Filed FEB 7 1924, 19

16 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb 9, 1924.

that I last saw him alive on Feb 8, 1924

and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Gen Debility (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Cushing M. D.

Feb 9 1924 (Address) 3100 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Feb 12 1924

20 UNDERTAKER Lilly & Zeiler.

ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83729

CERTIFICATE OF DEATH. 185 D 83729

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

2-FULL NAME Orlando Wilkinson

(a) RESIDENCE No 226 N Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) April 15/81

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	9	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robt. O. Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robt. Wilkinson
(Address) 226 N. Caroline

15 Filed FEB 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Trauma Of Brain(Probably Accident)

(Investigation Feb 14/24)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) J. S. H. Gallen, M. D.
(Coroner.)

Feb 12/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London. Park Cem

DATE OF BURIAL 2/13 1924

20 UNDERTAKER L. F. McCubbin

ADDRESS 130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83730

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1915 W. Franklin ST. 20 WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Elizabeth Cookran

(a) RESIDENCE. No. 1915 W. Franklin ST. 20 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Roland Cookran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Etta Mescott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr Roland Cookran
(Address) 1910 W. Franklin St.

15 Filed FEB 1 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 23. 1924. to Feb 10. 1924. that I last saw her alive on Feb 10. 1924. and that death occurred, on the date stated above, at 10-30 A m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) Over 6 Months

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry L. Shea M. D.

Feb 14. 1924 (Address) 1208 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 13 1924
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	217 3 Ave

N. B.—WHITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

(Griffin?)

D 83731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 83731

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 710 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hilbut Griffin

(a) Residence No. 2806 Eddick Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 23. 1923

7-AGE. 7 Mo 9 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balt. Md

PARENTS.

10-NAME OF FATHER Thos J Griffin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Dora Nash

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

11- (Informant) Thos Griffin

(Address) 2806 Eddick Ave

13- Robert F. Marriott, Registrar.

Filed FEB 21 1924 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 12 - 24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 20 19 24 to Feb. 12 19 24

that I last saw him alive on Feb. 12 19 24

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. Goldeman M. D.

2-12-1924 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park cem	Feb. 14 1924
20-UNDERTAKER. Robert Brookeman	ADDRESS COR CALHOUN HOLLINS ST

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83732

D 83732

CERTIFICATE OF DEATH. X 124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Biehl

(a) RESIDENCE NO. Frederick County Md ST. WARD Westminster Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miller

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer English & Sponsler

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Biehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Deanna Rumell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry C. Biehl

(Address) Westminster Md

15 Filed FEB 12 1924, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from February 10, 1924, to Feb. 12, 1924

that I last saw h— alive on Feb. 12, 1924

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 1X ds.

CONTRIBUTORY (Secondary) Acute Carbon Dioxid Poisoning (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb. 11

Was there an autopsy? No

What test confirmed diagnosis? Opinion

(Signed) [illegible], M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL Feb. 15 1924

20 UNDERTAKER H H Bankard & Son — ADDRESS Westminster Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 12 1924

Spec.—1-10-21—M&T—1500 Rks.

D 83733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 117

D 83733

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas Arthur Carey

(a) RESIDENCE NO. Elliott city ST., 4 WARD Ellicott City Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Carey

6 DATE OF BIRTH (month, day, and year) Oct 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman 486

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electric Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER — Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co

12 MAIDEN NAME OF MOTHER — Md

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Josephine Carey, Ellicott City (Address)

15 Filed FEB 1 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12/ 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1924, to Feb 12, 1924, that I last saw h— alive on Feb 12, 1924, and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis

Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia, bilateral

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Ellicott City

Did an operation precede death? Yes Date of 4/24/24

Was there an autopsy? —

What test confirmed diagnosis? Clinical symptoms — Blood culture Stool

(Signed) R. Pleger, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns. Ellicott City	Feb 14 1924
20 UNDERTAKER	ADDRESS
Scott M. Shaw	Ellicott City

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83734

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 83734

90

1-PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1611 Park Ave St. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Birdetta Hogan

(Residence in Baltimore: No. 1611 Park Ave St.: 25 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: — (Month) — (Day), 1874 (Year)

7-AGE: 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Tenn

PARENTS

10-NAME OF FATHER: George Rayfield

11-BIRTHPLACE OF FATHER (State or country): Va

12-MAIDEN NAME OF MOTHER: Mary Duggan

13-BIRTHPLACE OF MOTHER (State or country): Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Hogan

(Address) 1611 Park Ave

15-

FEB 12 1924

Robert P. Harrison,

....., 191.....

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb. (Month) 11 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan ....., 1920, to Feb. 11 1924

that I saw h alive on Feb. 11- ....., 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (Duration) ..... yrs. ..... mos. 1 ds

Contributory (SECONDARY) Chronic Myocarditis

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Standish McAleer M. D.

Feb 12, 1924 (Address) 1609 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Feb 14, 1924

20-UNDERTAKER: Martin Fahy Sons — ADDRESS: 1727 W North.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83735 ✓ 31 D 83735

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 S. Highland Ave ST., 7 WARD)

2-FULL NAME Rosa Hollaender Meyer

(a) RESIDENCE NO. 821 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Martin Meyer

6 DATE OF BIRTH (month, day, and year) June 6 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H. Eckstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co Pa

12 MAIDEN NAME OF MOTHER Eliza Anne Lightner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Archibald Eckstein 17 S. Highland Ave

15 Filed FEB 12 1924 ... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan ..., 1924, to Feb 10, 1924.

that I last saw her alive on Feb 10 1924.

and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

about (duration) 8 yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Not Ascertained

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) H. L. Packard M. D.

2-10, 1924 (Address) 5100 Adelbert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Private Burying Ground Feb 13 1924

20 UNDERTAKER Chas C. Miller ADDRESS 2334 Jefferson St

INSTRUCTIONS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Washington Boulst. 27 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Miss) Annie Olivia Konze

(a) RESIDENCE. No. 611 Washington Blvd ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 9 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Public School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Educational 068

(c) Name of employer Baltimore City.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Louis Konze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Jane Konze

(Address) 611 Washington Boulevard

15 Robert F. Mahoney Registrar

FEB 12 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1923, to February 12, 1924, that I last saw h[illegible] alive on Feb 11, 1924, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test

(Signed) J. M. Dellett, M. D.

(Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL FEB 14 1924

20 UNDERTAKER Geo W. Little — ADDRESS 2700 EDMONDSON AVE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16 21—M&T—1500 Blks.

D 83737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Home

CITY OF BALTIMORE: (No. 1112 N. Monroe ST., 20 WARD)

2-FULL NAME Bradley Thos. McCoy Sr.,

(a) RESIDENCE No. 1848 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1, 1924

7 AGE: Years | Months | Days: 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Bradley Thomas McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Linda Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mathews City, Va

14 Informant: Mr. Bradley McCoy Sr.

(Address): 1848 W Fayette St

15 [illegible] 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924 to Feb. 12, 1924

that I last saw him alive on Feb. 12, 1924

and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

General underdevelopment from birth

Atelectasis - since birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Goodman M. D.

19 (Address) Colonial Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Feb 13 1924

20 UNDERTAKER: W. J. Meekins Sons

ADDRESS: North Ave

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 1 21924

Cor.—1-12-23—M&T—100 Bks.

(Terro)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83738

100 901 D 83738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Torrie

(a) RESIDENCE NO 924 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) April 12-1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dominick Torrie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosie Costanzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Johns Hopkins Hospital (Address)

15 [illegible] 192 Robert F. Harrison, Registrar

EB 12 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia
Meningitis-(probably pneumococic)
(no autopsy)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Falls, M. D.
(Coroner.)

Feb 12/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	2/13/24
20 UNDERTAKER	ADDRESS
Geo. C. Duffy	1035 Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83739 HEALTH DEPARTMENT—CITY OF BALTIMORE

#8 3739

X117 D 83739

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

2-FULL NAME Henry allender

(a) RESIDENCE NO. Westminster Maryland ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1Y ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 7 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Brookside
(State or country) W. Va

PARENTS

10 NAME OF FATHER James H Allender

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) W. Va

12 MAIDEN NAME OF MOTHER Virginia Irving

13 BIRTHPLACE OF MOTHER (city or town) Eurora
(State or country) W Va

14 Informant James H Allender
(Address) Westminster Md

15 FEB 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 1924

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1924, to February 12, 1924, that I last saw him alive on February 12, 1924 and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 1Y ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. 1X ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb. 2-24

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & autopsy.

(Signed) James Hurst Wilkinson, M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb 15 1924
20 UNDERTAKER	**ADDRESS**
H Bankard & Son	Westminster Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83740 (Turner)

HEALTH DEPARTMENT—CITY OF BALTIMORE D/83740

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home Hosp. 492 REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 6 ST., WARD)

2-FULL NAME Mrs Agnes H. Turner.

(a) RESIDENCE NO. Centreville, Md. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
62 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER John Handerley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Sarah Salisbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Medford H. Turner

(Address) Centreville Md.

FEB 1 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to Feb 12, 1924; that I last saw her alive on Feb 12, 1924, and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism (duration) yrs. 8 hrs. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) L. M. Colvert, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Queenstown, Md. DATE OF BURIAL Feb 17 1924

20 UNDERTAKER H. E. Shafer ADDRESS Rock Hall Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Parker)

D 83741 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. + 49 D 83741

1-PLACE OF DEATH Church Home and Infirmary. 6 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Parker.

(a) RESIDENCE NO. Forrest City N. C ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 26 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emelia Buchboard Parker.

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Clerk. 009

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery business

(c) Name of employer O.F. Buchboard.

9 BIRTHPLACE (city or town) (State or country) Jackson Co. North Carolina

PARENTS

10 NAME OF FATHER Thomas Parker.

11 BIRTHPLACE OF FATHER (city or town) Jackson Co. (State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Emeline Coward.

13 BIRTHPLACE OF MOTHER (city or town) Jackson Co. (State or country) North Carolina.

14 Informant O F Beechboard. (Address) Caroleen N C.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar.

FEB 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Feb 12, 1924, that I last saw him alive on Feb 12, 1924, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

1 Tumor of Brain, Epithelioma

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Rectal Tumor Large.

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Jan 22. 1924 Jan 29. 1924.

Was there an autopsy? Yes. partial.

What test confirmed diagnosis? Operation.

(Signed) Cayetano Paniagua M. D.

19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrest City N C	Feb 13 1924
20 UNDERTAKER	ADDRESS
N E Shipley	Ashworth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Barnett)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83742

CERTIFICATE OF DEATH.

101-001 D 83742

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1049 W. Lexington ST., 18 WARD)

2-FULL NAME Phillip Barnett

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1049-W Lexington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 2-1905

7 AGE — Years: 18 — Months: 7 — Days: 6 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Public work

(b) General nature of industry, business, or establishment in which employed (or employer): Jewish Cty

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Penn

12 MAIDEN NAME OF MOTHER: Martha Milburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary Mrs Cooley

(Address) 1049 W. Lexington

15 Filed ..... ROBERT R. KRAUTER, Registrar

FEB 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 19 24

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 19 24, to Feb 9, 19 ..

that I last saw h[illegible] alive on Feb 8, 19 24

and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Cor Coronary Sclerosis

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter Dorsey, M. D.

19 (Address) 618 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Feb. 12, 1924

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mc Tierney

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83743

CERTIFICATE OF DEATH.

129 D 83743

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 6 WARD)

2-FULL NAME George McTierney

(a) RESIDENCE NO. 433 N. Durham St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie McTierney

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.U

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John McTierney

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Record.
(Address)

FEB 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/24 19

17 I HEREBY CERTIFY, That I attended deceased from 2/7/24, 19..., to 2/11/24, 19, that I last saw h[illegible] alive on 2/11/24, 19, and that death occurred, on the date stated above, at 4.25 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. W. McClay, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern md — DATE OF BURIAL Feb 13 1924

20 UNDERTAKER Edward Bryson — ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5322 Maple Av ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence O. Lee

(a) RESIDENCE NO. 5322 Maple Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie

6 DATE OF BIRTH (month, day, and year) July 21 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John H Lee

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mrs Annie O Lee

(Address) 5322 Maple av

15 Filed ..... 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1924, to Feb 11, 1924, that I last saw him alive on Feb 11, 1924, and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Scheurich, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 14 19
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 83745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D 83745

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 N. Streeper St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Kolb.

(a) Residence No. 517 N. Streeper St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Kolb

6-DATE OF BIRTH (month, day and year) Dec. 9, 1840

7-AGE. 83 yrs. 2 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Ulrich

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

11- (Informant) William N. Kolb

(Address) 1501 N. Montford Ave

FEB 13 1924

Filed ..... ROBERT R. KRAUTER, Registrar.

Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 10 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 17, 1924, to Feb 10, 1924, that I last saw h.... alive on Feb 7 1924, and that death occurred, on the date stated above, at 9 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Friedenwald M. D.

19 24 (Address) 800 N. Mount St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Pauls Com

DATE OF BURIAL. Feb 13 19 24

20-UNDERTAKER. H. Sander Sons

ADDRESS 1710 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83746

D 83746

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3131 E. Monument St., 7 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Doris E. Griffiths

(a) Residence No. 3131 E Monument St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 14, 1923

7-AGE. 0 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Thomas Griffiths

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wales

12-MAIDEN NAME OF MOTHER, Agnes Moxley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Agnes Moxley

(Address) 3131 E. Monument St.

FEB 13 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 11, 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 19 24 to Feb 11 19 24

that I last saw h alive on Feb 11 19 24

and that death occurred, on the date stated above, at 9:35 P. M.

The CAUSE OF DEATH* was as follows:

Grippe

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? Mt Sinai

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Todd Reinicker M. D.

2-11 19 24 (Address) 800 N. Mitchell St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn — DATE OF BURIAL. Feb 13 19 24

20-UNDERTAKER. H. Sander Sons — ADDRESS 1710 Druid

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S.—12-23-21—E.B.R.S.—400 Bks.

D 83747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83747

58-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Bond & Poplar Ave Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Brown

(a) Residence No. South Bond & Poplar Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6-DATE OF BIRTH (month, day and year) May 27 1869

7-AGE, 55 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Newfoundland

PARENTS.

10-NAME OF FATHER Edward Payne

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England

12-MAIDEN NAME OF MOTHER Mary Hale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-(Informant) Wm. H. Brown

South Bond & Poplar Ave City

15-Filed [illegible] 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Feb 11, 1924, that I last saw h... alive on Dec 1, 1923, and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious anemia

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Blood test

(Signed) Evan F. Kelly, M. D.

2/12, 1924 (Address) 3705 Jones Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb. 14, 1924

20-UNDERTAKER, George J. Smith — ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 83748

REGISTERED NO.

1-PLACE OF DEATH D 83748

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carol Plinket

(a) RESIDENCE No. 815 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 9 1924 unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Plinket

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Alice -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Johns Hopkins Hospital (Address)

15 Filed FEB 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

47

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia- Heredity Syphillis

(Autopsy at Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

Feb 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL FEB 12 1924

20 UNDERTAKER ADDRESS

Commissioner of Health,

[illegible]

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Eks.

D 83749

HEALTH DEPARTMENT—CITY OF BALTIMORE

83749

CERTIFICATE OF DEATH.

6 112

1-PLACE OF DEATH Hebrew Aged Home

City of BALTIMORE: (No. 115 Aisquith Street St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Caplan Caplan

(a) Residence No. 115 aisquith St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Caplan

6-DATE OF BIRTH (month, day and year)

7-AGE. 74 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nil

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-(Informant) Jack Lewis

(Address) 1439 Eutaw St

15-FEB 1 31924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-12-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1923, to Feb 11th 1924, that I last saw him alive on " " 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Same

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L Weiner M. D.

2-12, 1924 (Address) 30 S. B'way

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 2—13 1924

20-UNDERTAKER, Jack Lewis 1439 — ADDRESS Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

83750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 83750

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 21 WARD)

2-FULL NAME Harry Pearlman

(a) RESIDENCE NO. 46 S. Green St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer): Hat

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hospital Records

15 Filed FEB 13 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febr 12 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 24, 19..., to Feb 12, 1924.

that I last saw h[illegible] alive on Febr 12, 1924.

and that death occurred, on the date stated above, at 12 Midday

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) J. Hunt Hart M. D.

19..... (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Orphan Asy

DATE OF BURIAL: 2/13 1924

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83751

CERTIFICATE OF DEATH.

D 83751

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.) 155 E. Lanvale St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dagmus Clagett.

(a) Residence No. Rockville Md St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Henrietta Darnall

6-DATE OF BIRTH (month, day and year) Dec 18 1837

7-AGE. 86 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Potomac Montgomery Co Md

PARENTS

10-NAME OF FATHER Orath Clagett.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). md

12-MAIDEN NAME OF MOTHER, Margret Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). md

14- (Informant) Mrs. Warner

(Address) 15 E Lanvale St.

15- FEB 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 19 24 to Feb. 12 19 24

that I last saw h.. alive on Feb 12 19 24

and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 5 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? usual

(Signed) Harvey E Beach M. D.

, 19 (Address) 20 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Potomac Cem Montgomery Co Md

DATE OF BURIAL. Feb. 15 1924

20-UNDERTAKER John Armistead

ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83752

CERTIFICATE OF DEATH.

D 83752

REGISTERED No. 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2129 Woodbury Ave (St.) (WARD) 13

2-FULL NAME George Ann Sykes

(a) RESIDENCE No. 2129 Woodbury Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wesley A. Sykes

6 DATE OF BIRTH (month, day, and year): Aug. 4, 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	6	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Richard Hager.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Mary Armacost

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Wesley A. Sykes

(Address) 2129 Woodbury ave.

15 FEB 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1923, to Feb 11th, 1924, that I last saw her alive on Feb. 11th, 1924, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hem. Stenosis. 2/v Nephritis

Diabetes 1 year (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) R. G. Dieter, M. D.

4/13, 1924 (Address) 1727 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: 2/14 1924

20 UNDERTAKER: J. WALTER DAVIS, FUNERAL DIRECTOR

ADDRESS 3307 Paine St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-00 D 83753

D 83753

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Baby Charson

(a) RESIDENCE NO. 1012 Exeter ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... dd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

PARENTS

9 BIRTHPLACE (city or town) (State or country) Phila Pa Mother Md - Father Russia

10 NAME OF FATHER Isaac Charson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isaac Charson (Address) 101 S. Exeter St

15 FEB 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1924 to Feb 11, 1924.
that I last saw h alive on Feb 11, 1924.
and that death occurred, on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos dys

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Spidori, D. ....., M. D.

Feb. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 2/13 1924

20 UNDERTAKER A. Luiren & Bro — ADDRESS 427 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83754

CERTIFICATE OF DEATH.

D 83754

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1529 Light St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hellie May Jackson.

(a) RESIDENCE. NO. 1529 Light St. ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4. mos. 10. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	4,	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward Lee Jackson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Lilian C. Sunderland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Edward Lee Jackson (Father).

(Address) 1529 Light St.

15 Filed FEB 1 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1924 to Feb 12 1924 that I last saw h[illegible] alive on Feb 12 1924 and that death occurred, on the date stated above, at 1.40 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2-12-1924 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Feb. 14, 1924

20 UNDERTAKER ADDRESS

A. Howard Evans. 1428 S. Charles St.

Cor.—1-12-23—M&T—100 Bks.

D 83755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 83755

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1333 N. Carey St., 15 WARD)

2-FULL NAME John N. Caldwell

(a) RESIDENCE NO. 1333 N. Carey St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1870

7 AGE: Years 53 yrs. | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Wm. F. Caldwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Sarah J. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Annie C. Smith
(Address) 1333 N. Carey St.

15 Filed FEB 1 31924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophy Heart dilation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

(Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn | DATE OF BURIAL: 2-13 1924

20 UNDERTAKER: H. P. Chase & Son | ADDRESS: 1409 Hood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83756

CERTIFICATE OF DEATH.

D 83756

1-PLACE OF DEATH Faust Avenue near Franklintown Rd

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Amanda Root

(a) RESIDENCE NO. Faust ave & Windsor Mill Rd WARD Franklintown

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick County (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Root

11 BIRTHPLACE OF FATHER (city or town) Frederick County (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Ann Zeigler

13 BIRTHPLACE OF MOTHER (city or town) Frederick County (State or country) Maryland

14 Informant Mrs. Helen Root Lilly (Address) Thurmont, Maryland

15 FEB 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1924, to Feb. 12 1924, that I last saw h[illegible] alive on Feb. 11 1924, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

arteri-sclerosis. Chronic interstitial nephritis. Hypostatic pneumonia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage. (Paralysis)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical

(Signed) Wallace S Hulett, M. D.

Feb. 1924 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Frederick Md

DATE OF BURIAL Feb 15 1924

20 UNDERTAKER Jos J Cook

ADDRESS 1003 W Balto

Spec.—1-10-21—M&T—1500 Bks.

(Sluzewski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83757

24-001

D 83757

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S. Collington Ave ST., WARD)

2-FULL NAME Frank Sluzenski

(a) RESIDENCE No. 415 S. Collington Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Sluzenski

6 DATE OF BIRTH (month, day, and year) Mar 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer B and O

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Sluzenski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Sluzenski (Address) 415 S Collington Ave

15 Filed FEB 1 1924 ROBERT [illegible] CRAMER Registrar [illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1924 to Feb. 10, 1924.

that I last saw him alive on Feb 10, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis, Chron Nephritis Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A T Ries, M. D.

Feb 12, 1924 (Address) 245 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Feb 7 1924

20 UNDERTAKER F W Ozazenski — ADDRESS 1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83758

REGISTERED NO. 57 D 83758

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Monument + Rutland Sts Hebrew Hospital ST., V WARD)

2-FULL NAME Mrs. Josephine Kacpka

(a) RESIDENCE NO. 1528 Hanover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 Yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (01) HUSBAND of Peter Kacpka

6 DATE OF BIRTH (month, day, and year) Feb 16 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ed Blenka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant J Kacpka

(Address) 1528 Hanover St

Filed FEB 1 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1924

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1924, to Feb 11, 1924, that I last saw her alive on Feb 11, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure or Insufficiency

(duration) yrs. mos 1 14 ds.

CONTRIBUTORY (Secondary) Diabetes + gangrene 4 weeks 2 yrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isidor D. Fry, M. D.

Feb. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL Feb 15 1924

20 UNDERTAKER F. H. Bazenski ADDRESS 534 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83759 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D. 83759

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Abbottston ST. 9 WARD)

2-FULL NAME Charles H. E. Pletsch

(a) RESIDENCE No. 1611 Abbottston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Pletsch

6 DATE OF BIRTH (month, day, and year) Oct 10th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	51	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 004

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry E. Pletsch

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Kraft

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Howell G. Pletsch (Address) 1611 Abbottston St.

15 FEB 13 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 6 1924 to Feby 11 1924.

that I last saw him alive on Feby 11 1924.

and that death occurred, on the date stated above, at 8 12 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

General Paralysis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

(Signed) H. Young Wallbrook, M. D.

2-12 1924 (Address) 16 N Gravely ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Feb 14 1924
20 UNDERTAKER Howell Lucas and Sons	ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 83760

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME Caroline Isabell Tinsley

(a) RESIDENCE NO. 1617 N. Calvert ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Harvey Tinsley

6 DATE OF BIRTH (month, day, and year): March 20 1901

7 AGE — Years: 22 — Months: 11 — Days: 22 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Harry Sermon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary Trautfellow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Charles H Tinsley

(Address): 1617 N Calvert St

15 FEB 1 31924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): FEB 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9. 1924. to Feb. 13. 1924.

that I last saw her alive on Feb 13. 1924.

and that death occurred, on the date stated above, at 5 4 m.

The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis

Metritis and Parametritis

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Findings

(Signed) ..... M. D.

2/23 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: FEB 15 1924 19

20 UNDERTAKER: Geo W Little — ADDRESS: 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83761

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 83761

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520-Vine ST., 19 WARD)

2-FULL NAME Daniel Allen

(a) RESIDENCE NO. 1520-Vine ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-27-23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Walter Allen

11 BIRTHPLACE OF FATHER (city or town) Crew
(State or country) Va.

12 MAIDEN NAME OF MOTHER Bessie Blaine

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Bessie Allen.
(Address) Mother, 1520-Vine St.

15 Filed FEB 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12-1924

17 I HEREBY CERTIFY, That I attended deceased from 2/11, 1924, to 2/12, 1924, that I last saw him alive on 2/12, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) undefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Mal-Nutrition

(duration) undefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Jackson M. D.

FEB 2 1924 19 (Address) 508 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL Feb. 14 24

20 UNDERTAKER Joseph A Farrell

ADDRESS 2314 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83762

CERTIFICATE OF DEATH.

91-602

D 83762

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2901 Chelsea Terrace ST., 15 WARD)

2-FULL NAME Emily Jane Sumwalt

(a) RESIDENCE NO. 2901 Chelsea Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. K. Sumwalt

6 DATE OF BIRTH (month, day, and year) Nov 14 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER — Kreglo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Charles K. Sumwalt

(Address) 2901 Chelsea Terrace

15 Filed FEB 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 — 12 — 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 2, 1924, to Feby 12, 1924, that I last saw h alive on Feby 8, 1924, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General arteriosclerosis.

(duration) 10? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry D. McCarty M. D.

2-18, 1924 (Address) 837 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Feby 14 1924

20 UNDERTAKER Chas. T. Black — ADDRESS 742 W. North ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83763

CERTIFICATE OF DEATH.

11-6 D 83763

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 770 Sarah Ann ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Banks

(a) RESIDENCE No. 770 Sarah Ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Servant

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Grant Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lula Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Charles Banks
(Address) 509 Aisquith

15 Filed FEB 1 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1924, to Feb 12, 1924,

that I last saw her alive on Feb 11, 1924,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Williams E Burton, M. D.

Feb 12, 1924 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	2-14 1924
20 UNDERTAKER David Easton	ADDRESS 976 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

See Letter in file Oct 28-1924 from Claude L. Dyer M.D.

D 83764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 83764

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

2-FULL NAME Phillip Smith

(a) RESIDENCE NO. Bay View Hospital. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ~~1849~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
~~75~~ 64				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from October 1 1923 to February 12 1924, that I last saw him alive on February 11. 1924, and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Detonation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab.

(Signed) Claude L. Dyer, M. D.

2-12-24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. Cathedral Cem

DATE OF BURIAL 2-15 1924

20 UNDERTAKER David Curtis

ADDRESS 946 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

1691 5 a/p.m. 10 D 83765

CERTIFICATE OF DEATH.

+ 90 D 83765

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 18 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Washington

(a) RESIDENCE NO. 1019 Vine St ST., ... WARD 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Feb 15-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Lottie Washington

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19..... ROBERT R. KRAUTER, Registrar

FEB 1 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11-1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924, to Feb 11, 1924, that I last saw him alive on Feb 11, 1924, and that death occurred, on the date stated above, at 10 19 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Aortic Insufficiency; Myocardial Insufficiency

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary infarction Broncho-pneumonia

(duration) ..... yrs. 2-3 mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) J. R. Rydent M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL 2-14 1924

20 UNDERTAKER Dan'l Eppes

ADDRESS 916 Cam

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bkc.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 83766

CERTIFICATE OF DEATH.

101 09 B 83766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 N. Vincent ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Johnson

(a) RESIDENCE NO. 537 N. Vincent ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johnson

6 DATE OF BIRTH (month, day, and year) Jan. 6-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Westley Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. Eastar

(Address) 216 Cross

15 Filed FEB 1 1924, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 30/24, 19.., to Feb. 11, 1924, that I last saw him alive on Feb. 10, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) James M Hayer, M. D.

2/11, 1924 (Address) 513 N Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 2-14 1924

20 UNDERTAKER Wm Eastar

ADDRESS 216 Cross

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83767

CERTIFICATE OF DEATH.

129 D 83767

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2728 Winchester ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Oliver Elliott,

(a) RESIDENCE. No. 2728 Winchester ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Catherine Ann Elliot

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Henry Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary E. Farring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Catherine Ann Elliott

(Address) 2728 Winchester St.

15 FEB 13 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Feb. 11, 1924, that I last saw h.. alive on Feb. 11, 1924, and that death occurred, on the date stated above, at 6 55A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John B. Quinn, M. D.

2/2, 1924 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 15th 1924
20 UNDERTAKER	ADDRESS
Thos C. Miller	2334 Jeff

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83768

CERTIFICATE OF DEATH.

90 D 83768

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 419 Loudon Avenue St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Bitters

(a) Residence No. 419 Loudon Avenue St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE.	If LESS than 1 day,
70 yrs. -- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis Bitters

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Do not know

14- (Informant) Mrs. John K. Miller
(Address) 419 Loudon Avenue

15- Filed FEB 13 1924, 192.. Robert P. Harrison, Registrar.
Verified Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov, 1923 to Feb 12, 1924

that I last saw him alive on Feb 12, 1924

and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. C. Wiring M. D.

, 19 (Address) 4000 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cemetery	2/14 ....., 19....
20-UNDERTAKER Henry W. Mears & Son	ADDRESS 805 N. Calvert

R B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21—E.B.R.S.—400 Rks.

D 83769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1140 Forrest St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hagerty

(a) Residence No. 1140 Forrest St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 40 -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Michael J. Hagerty

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE.			If LESS than 1 day,
63 yrs.	-- mos.	-- ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Bartholomew Keelty

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Kane

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. Annie Keane
(Address) 1140 Forrest St.

15- Filed FEB 13 1924 Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-11-24

17- I HEREBY CERTIFY, That I attended deceased from 2-1- 19 24 to 2-11 19 24

that I last saw her alive on 2-11 19 24

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Vaginal Examination

(Signed) Dr. Adam Miller M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	2/14 19 24
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

Burial Permit Clerk.

FR. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Hurst)

D 83770

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. ST. 16 WARD)

2-FULL NAME Elizabeth Hurst

(a) RESIDENCE. No. 733 Forrest ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/19/-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	9	25	

8 OCCUPATION OF DECEASED (milliner)

(a) Trade, profession or particular kind of work Mulinery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo A Hurst

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mimi Jane

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Attended deceased
(Address)

15 Filed FEB 13 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 12, 1924, that I last saw h... alive on Feb 12, 1924, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter Clay, M. D.

(Address) 545 Fulton Ave

3/3, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	2/14 1924
20 UNDERTAKER H. C. Brauning's Son	ADDRESS 5 17 N.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83771

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 N Catherine ST., 20 WARD)

2-FULL NAME Lydia C Bacon

(a) RESIDENCE NO. 25 N. Catherine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. E Bacon

6 DATE OF BIRTH (month, day, and year) Jan 31 1857

7 AGE Years 65 Months Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jas E Bacon (Address) 25 N Catherine

15 Feb 13, 1924 Robert P. Harrison, Registrar

FEB 13 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to Feb 11, 1924, that I last saw h[illegible] alive on " " , 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis — 5 yrs

Acute Bronchitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw J Coolahan, M. D.

2/13, 1924 (Address) 724 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 2/16/24

20 UNDERTAKER George A Tinley Funeral Director — ADDRESS

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83772

D 83772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette and Payson ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ring

(a) RESIDENCE NO. 1803 W. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22 1869

7 AGE — Years: 54 — Months: 7 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Excavation Dept

(b) General nature of industry, business, or establishment in which employed (or employer): Newspaper Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Stephen Ring

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie McEvoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Ivy Hesbrook

(Address) 1443 W Baltimore St

15 Filed FEB 13 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1924, to Feb. 11th, 1924, that I last saw him alive on Feb. 11th, 1924, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pyloric Stenosis (duration) yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 10th

Was there an autopsy? No —

What test confirmed diagnosis? Exploratory operation

(Signed) H. H. Powell, M. D.

2/11/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 2/15/24

UNDERTAKER: Geo A Farley Sulton — ADDRESS: Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83773

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 83773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp.

CITY OF BALTIMORE: (No. 1112 N. Mount ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine Lovelace

(a) RESIDENCE No. 1324 N. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Lovelace

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1875

7 AGE 49 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER (?) Deceased

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Deceased

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Chas. Lovelace

(Address) 1327 Eutaw St.

15 Robert F. Halfpenny, Burial Permit Clerk. Registrar

FEB 13 1924 , 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1924, to Feb. 13, 1924 that I last saw h e alive on Feb. 13, 1924 and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Interstitial Nephritis
Several years (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia 5 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. A. Brosman, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pennyman, Md

DATE OF BURIAL Feb. 15 1924

20 UNDERTAKER J. R. Deer

ADDRESS, Md Sykesville

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83774

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

2-FULL NAME Angelos George

(a) RESIDENCE NO. 221 Harrison st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Nick George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 3 1924, 19 Robert T. Marriott, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1924, to Feb. 12, 1924, that I last saw him alive on Feb. 12, 1924, and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lalley, M. D.

2-18-1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL WOODLAWN CEM

DATE OF BURIAL 2/15 1924

20 UNDERTAKER ROBERT T. BROOKS & SON

ADDRESS CALHOUN & HOLLINS ST

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Fax

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83775

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 E. 23 dek ST., 17 WARD)

REGISTERED NO. 1924 D 83775

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Fax

(a) RESIDENCE No. 307 E 23 dek ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Fax

6 DATE OF BIRTH (month, day, and year): [illegible] 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country): Tuscon Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. R.G. Ellis

(Address): 1225 Ashland ave

15 FEB 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1924, to Feb 11, 1924,

that I last saw her alive on Feb 11, 1924,

and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

and Hyperpiretica

(duration) 1 yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. H. Ellis, M. D.

, 19 (Address) 1226 E 23 dek

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 14 1924
20 UNDERTAKER	**ADDRESS**
Mrs. R.G. Ellis	1225 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 83776 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-09 D 83776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Aisquith ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Hodges

(a) RESIDENCE No. 604 Aisquith ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Unknown Feb/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Mrs. R.A. Elliott (Address) 1725 Ashland Ave

15 Filed FEB 14 1924, 192 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to him death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) /S/ S.S. Vollum, M. D. (Coroner.)

Feb 13/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 15 1924
20 UNDERTAKER Mrs. R.A. Elliott	ADDRESS 1725 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83777

CERTIFICATE OF DEATH

1924

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST., 6 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Sampson

(a) RESIDENCE NO 122 Dallas St North ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Sampson

6 DATE OF BIRTH (month, day, and year) Dec 22/1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	1	18	

8 OCCUPATION OF DEGEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Daniel Moore
(Address) 122 N. Dallas St.

15 Filed FEB 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Thoracic Hemorrhage- Pistol shot through heart & left Lung.
(Homicide-said to have been fired by 2d Wm Sampson) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Hoffacker, M. D.
(Coroner.)
Feb 11/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Feb. 14 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Frederick Erdman Spies)

D 83778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D 83778

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital 10 ST., ... WARD)

2-FULL NAME Fdk. Erdman Spies

(a) RESIDENCE No. 3241 Tunstall ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25-1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Fdk. Florian Spies

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

31

12 MAIDEN NAME OF MOTHER Lina M. Freund

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant O B. Towles
(Address) 1432 William ST

15 Filed FEB 14 1924 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10 1924

17 I HEREBY CERTIFY, That I attended deceased from 1.25.24, 19..... to 2.10.24, 19.....

that I last saw h.. alive on 2.10.24, 19.....

and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
(Primary)

(duration) ..... yrs. ..... mos 16 ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) O B. Towles, M. D.

2/13/24, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity C. Donnelly — DATE OF BURIAL 2/14/24

20 UNDERTAKER Geo Weber, Son — ADDRESS 2503 Edmondson ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83779

CERTIFICATE OF DEATH.

100500 D 83779

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 83779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Johns ST. 14 WARD)

2-FULL NAME Eleanor Evans Woolford

(a) RESIDENCE NO. 1533 Johns St. ST., ... WARD 10 am
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1854

7 AGE 69 Years 5 Months 24 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Capt. John Woolford

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Caroline Evans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Rosa Woolford
(Address) 1533 Johns St

FEB 14 1924 ROBERT. R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1924, to Jan Feb 11, 1924, that I last saw h[illegible] alive on Feb 11 1924, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Stewart McColgan, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL July 14 1924

20 UNDERTAKER John B. Spence — ADDRESS 1325 N Caroline St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

12 aug

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83780

143-03 83780

CERTIFICATE OF DEATH.

REGISTERED NO. 83780

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1809 Prestman ST., 15 WARD)

2-FULL NAME Lena Carbona

(a) RESIDENCE NO. 1809 Prestman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfredo Carbona

6 DATE OF BIRTH (month, day, and year): August 12 1898

7 AGE: Years 25 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Antonio Manchini

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Mectiatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Roland Thrancer

(Address): 1809 Prestman

15 FEB 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 1924 to Feb 13 1924, that I last saw h alive on Feb 13 1924, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pneumonia Bilateral follow

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Cerebral Date of Feb 8 24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos L. Valentino M. D.

(Address) Feb 13. 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 2/16 1924

UNDERTAKER: Frank V. Pipitone

ADDRESS: 800 E 33rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83781

90 D 83781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 E. Baltimore St., ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Frohlich Jr

(a) RESIDENCE NO. 47 Bellevue Av. Ravenna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Frohlich

6 DATE OF BIRTH (month, day, and year) May 13, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steam Fitter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Arundel Co. Gas Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas. Frohlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Pfeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant C. Frohlich
(Address) 47 Bellevue Ave

15 Filed FEB 14 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.), M. D.

Feb 14 192 (Address) 1654 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 4 mo hours

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Feb 15 1924
20 UNDERTAKER	ADDRESS
H. Vander & Sons	701 Flat St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Schwessinger)

D 83782

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 83782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 S. Clinton ST., 76 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schwessinger

(a) RESIDENCE No. 406 S. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: George M Schwessinger

6 DATE OF BIRTH (month, day, and year): Feb 27 1847

7 AGE: Years 76 Months 11 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Adam

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. G. Schwessinger 406 S. Clinton St.

15 Filed ..... 19.....

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, ~~day, and year~~): Feb 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1922, to Feb 13, 1924.

that I last saw h[illegible] alive on Feb 12, 1924.

and that death occurred, on the date stated above, at 4.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H L Pickard M. D.

Feb 13 1924 (Address) 3108 Abell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Feb 16 1924

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1700 Pied

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83783

CERTIFICATE OF DEATH.

11 2D 83783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 E. Lombard WARD 3)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Janet Lewis

(a) RESIDENCE NO. 1425 E Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. H. Lewis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	28	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ann Farrar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant J. H. Lewis
(Address) 1425 E. Lombard St

15 Filed ..... 192 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. 1/2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
Coroner

Feb 13th 1924 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Usbury Cem — DATE OF BURIAL 2/15 1924

20 UNDERTAKER Jas. M. Skinner — ADDRESS 1625 E. Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Standard Guano Co. Curtis Bay. ST., 5 WARD)

REGISTERED NO. 187 D 83784

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Banks. (C).

(a) RESIDENCE NO 520 Lewis Street. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary E. Banks. (C).

6 DATE OF BIRTH (month, day, and year) May 9, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	9	3.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cockysville Md.

PARENTS

10 NAME OF FATHER John Banks. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Maria -----(C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mary E. Banks. (C) (wife)
(Address) 520 Lewis Street.

15 Filed FEB 14 1924 ROBERT R. KRAUTH Registrar
Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage.
due to crushing injuries to the face, shoulder and ribs. Accidentally caught in revolving machine.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)
Feb, 13th, 1924. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosbury Cem. DATE OF BURIAL 2/16 1924

20 UNDERTAKER Jas. M. Skinner ADDRESS 1625 E. Mad. St.

Cor.—1-12-23—M&T—100 Bks.

D 83785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

202 D 83785

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. John's Hopkins Hospital ST., WARD)

2-FULL NAME Dorothy Heuer

(a) RESIDENCE NO. 31 N. Streeper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0-0
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City.

PARENTS

10 NAME OF FATHER Wm O. Heuer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss.

12 MAIDEN NAME OF MOTHER Catherine A. Scheuerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm O. Heuer
(Address) 31 N. Streeper St

15 Filed FEB 4 1924, 192 ROBERT M. KRAUTH, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Choked by rubber nipple lodging in throat which was used as pacifier.

(Nipple recovered at hospital)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Collins, M. D. (Coroner)

Feb 14, 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 2/15 1924

20 UNDERTAKER Philip Harvig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83786

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N. Calvert ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Armanda Kunkel

(a) RESIDENCE NO. 421 N. Calvert ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 8 14 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan'l Kunkel (Separated)

6 DATE OF BIRTH (month, day, and year) Sept 1, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5-1			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter's
(b) General nature of industry, business, or establishment in which employed (or employer) Helper
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Pa.

PARENTS

10 NAME OF FATHER Jno. Kunkel

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER A. Snyder

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Penn.

14 Informant Brother of above deceased (Wilhelmina Kunkel)
(Address)

15 Filed ..... 192 ..... Registrar

FEB 14 1924 ROBERT R. KRAUTER
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. dis. heart

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Kirby ....., M. D.
(Coroner)

Feb 14 192 4 (Address) Mt. Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shrewsbury Pa.

DATE OF BURIAL 2/15 192 4

20 UNDERTAKER Philip Henrig

ADDRESS 2316 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 FD 83787

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fr. Sq Hospital ST., 7 WARD)

2-FULL NAME James. Cantell.

(a) RESIDENCE No. 735 N Wash St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Century

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) Ø
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Chas Cornell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Anna Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Elsie Cornell
(Address) 735 N Washington st

15 Filed FEB 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot Wound
Homicide

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. ½ ds.

(Signed) Edward R Rhodes M. D.
(Coroner.)

2-14-, 192 (Address) 1436 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. in the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waynesboro Pa	Feb 15th 1924
20 UNDERTAKER	ADDRESS
A Jones	111 S. Gilmor st

Spec.—1-10-21—M&T—1500 Bks.

Zientek

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83788 80 D 83788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Hill ry ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Zientek

(a) RESIDENCE NO. 914 Hill ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Teofar Zientek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Supadzyska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant Mary Zientek

(Address) 914 Hill st

Filed FEB 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 13. 1924

17 I HEREBY CERTIFY, That I attended deceased from February 13. 1924. to February 13. 1924. that I last saw h. alive on February 13. 1924. and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

(a) Spasm

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Intussusception (acute)

(duration) 1 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? vomiting

(Signed) E. J. Sommerkamp Jr. M. D.

2-14. 1924 (Address) 722 S. Ann st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Feby. 14, 1924.

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann St.

MARGIN RESERVED FOR RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Bks.

D 83789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83789

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 Hanover ST., 22 WARD)

2-FULL NAME Charles Dyson

(a) RESIDENCE No. 654 Hanover St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower

6 DATE OF BIRTH (month, day, and year): Sept. 7-1846

7 AGE — Years: 78 — Months: 5 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Brickmaker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Charley Dyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Carrie Bush (Address) 657 Hanover

15 Filed FEB 1 1926 19 ROBERT R. KRAUTER Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/17/1926

17 I HEREBY CERTIFY, That I attended deceased from 2/8/26, to 2/17/26, that I last saw him alive on 2/17/26, and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Disease (duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Feb'y 19 1926

UNDERTAKER: Wm. Lee Hooper — ADDRESS: 906 N. Carey St

MARGIN RESERVED FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Bks.

D 83790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Smith ST., 16 WARD)

2-FULL NAME Hattie Williams

(a) RESIDENCE NO. 1225 E Smith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Williams

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) West River

(State or country) A. A. Co., Md

PARENTS

10 NAME OF FATHER Major Gross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Benjamin Hilliams

(Address) 1225 Smith

FEB 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924 to Feb 12, 1924

that I last saw her alive on Feb 12, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H. S. McCard M. D.

2/14 1924 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Feb 15 1924

20 UNDERTAKER Hamilton Chas Bond

ADDRESS 410 Mosher

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Howard Johnson

B 83791 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 114 B 83791

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 645 Pierce St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Johnson

(Residence in Baltimore: No. 645 Pierce St.; yrs. 34 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1890 (Year)

7-AGE: 34 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Jonas Johnson

11-BIRTHPLACE OF FATHER. (State or Country): Md

12-MAIDEN NAME OF MOTHER: Cora Jones

13-BIRTHPLACE OF MOTHER. (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Johnson

(Address) 645 Pierce St

15- Filed FEB 14 1924 192.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Feb 13 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Bright's Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

..... 192.... (Address) .....

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL, Feb 17 192 4

20-UNDERTAKER, Chas W Chase ADDRESS 450 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Boldin

D 83792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83792

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2445 Ettinge St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Boldin

(a) Residence No. 2445 Ettinge St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, Col

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Boldin

6-DATE OF BIRTH (month, day and year) 1894

7-AGE. 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Employment

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Allen Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-(Informant) Lucie Johnson

(Address) 2445 Ettinge St

15-FEB 14 1924

Filed ..... 192... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 12, 1924

17-I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924, to Feb 12, 1924, that I last saw h[illegible] alive on Feb 12, 1924 and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Gabriel Churchill M. D.

Feb 13, 1924 (Address) 1534 E. Lan

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem.	Feb 14, 1924
20-UNDERTAKER.	**ADDRESS**
Mrs James H Dennis	Mrs J H Dennis 1509 Druid Park Lane

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16372
16-2-6

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83793

D 83793

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Louis Brach

(a) RESIDENCE NO. 344 S. Calhoun St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Brach

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Christian Brach

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Vocland

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 FEB 14 1924 ROBERT A. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1924, to Feb 12, 1924.

that I last saw him alive on Feb 12, 1924.

and that death occurred, on the date stated above, at 1438 m.

The CAUSE OF DEATH* was as follows:

Pneumonia - bronchs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cancer - stomach

(duration) 1 (9) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 2/9/24

Was there an autopsy? no

What test confirmed diagnosis? operative

(Signed) Walter B. Stewart, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Feb 15 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E Fairmount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

936 E Monument St
2nd Medo

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83794

CERTIFICATE OF DEATH.

129

D 83794

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Aisquith Street 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen Peterson

(a) Residence No. 815 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-Sex: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John Peterson

6-DATE OF BIRTH (month, day and year): Feb-11-1887

7-AGE, 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): John Peterson

(Address): 815 Aisquith Street

15- FEB 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb. 13/924

17- I HEREBY CERTIFY, That I attended deceased from Feb 10th 1924 to Feb 17 1924

that I last saw her alive on Feb 13 1924

and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria

(Signed) John D Fick M. D.

2/13/1924 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	2/15/24 19
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83795

CERTIFICATE OF DEATH.

65-002

D 83795

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 404 E 28 ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm A Grove

(a) RESIDENCE. NO. 404 E 28 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lettie M Grove

6 DATE OF BIRTH (month, day, and year) Sept 21, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Leroy Grove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Lettie M Grove

(Address) 404 E 28th St

15 Filed ... 19 ROBERT R. KRAUTER, Registrar

FEB 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to Feb 13, 1924, that I last saw h[er] alive on Feb 13, 1924, and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hodgkins Disease

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1506 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb 16, 24 19
20 UNDERTAKER	ADDRESS
Wm Lentz & Son	E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83796

D 83796

CERTIFICATE OF DEATH.

43

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 N. Mount St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hudson E. Wood

(a) Residence No. 606 N. Mount St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Wood

6-DATE OF BIRTH (month, day and year): Aug. 31, 1851

7-AGE: 72 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery 034

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Harford Co. Md.

PARENTS.

10-NAME OF FATHER: Hudson Wood

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Harford Co. Md.

12-MAIDEN NAME OF MOTHER: Elizebeth Wareham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Harford Co., Md.

14- (Informant): Wife Mrs. Sarah Wood

(Address): 606 N. Mount St.

15- FEB 14 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1922, to Feb 12 1924, that I last saw h—live on Feb 12 1924, and that death occurred, on the date stated above, at 11 a—m.

The CAUSE OF DEATH* was as follows:

Carcinoma of superior maxillary and surrounding adjacent tissue

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1923

Was there an autopsy? No

What test confirmed diagnosis? Lab & Clinical

2/3 (Signed) Bernard T. Lamb M. D.

, 1924 (Address) 1707 Eamondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Salem Ha. Harford Co. DATE OF BURIAL, Feb. 15, 1924

20-UNDERTAKER. Edmund W. Conklin ADDRESS 924 E. Eager Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

83797

CERTIFICATE OF DEATH.

90 ✓

D 83797

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Barclay ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas P. Lacy

(Residence in Baltimore: No. 2124 Berkley st. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-~~SINGLE,~~ MARRIED, ~~WIDOWED,~~ OR ~~DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, April 9 (Month) (Day), 1854 (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Select
(b) General nature of industry, business, or establishment in which employed (or employer) Metal Worker

9-BIRTHPLACE, (State or Country), Washington. D.C.

PARENTS.

10-NAME OF FATHER, John Lacy.

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosa Brown.

(Address) 2124 Barclay st

15- FEB 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 11th (Month) (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1923, to Feb 11 1924, that I saw h~~im~~er alive on Jan 31 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Organic heart disease

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward C. Beach M. D.

Feb 12, 1924 (Address) 843 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Feb. 15, 1924

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Harford ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002 D 83798

1-PLACE OF DEATH Maryland General Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. 108 S. Robinson ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann English

(a) RESIDENCE No. 108 S. Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 7 1923

7 AGE — Years — Months — Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George English

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Blanch Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant mother

(Address)

15 Filed FEB 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1924, to Feb 13, 1924, that I last saw her alive on Feb. 13, 1924, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

Acute Cardiac Dilatation

(duration) yrs. mos. days

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) Jno A Yamokins, M. D.

, 19 (Address) 11 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: Feb. 15 1924

20 UNDERTAKER: George J. Ruth

ADDRESS: 1730 Harford Ave

Spec.—8-24-14—M. & T.—200(Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

154-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH B 33799 REGISTERED NO. C B 33799

CITY OF BALTIMORE: (No. Maternity - Franklin Sq. St. Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby boy Lima

(Residence in Baltimore: No. Maternity Franklin Sq Hosp St.; ...yrs., ...mos. ...ds.)

317 W. Lan.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	white	—

6-DATE OF BIRTH, 2 - 3 - 24, 1
(Month) (Day) (Year)

7-AGE, ...yrs. ...mos. 10 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General natnre of industry, business, or establishment in which employed (or employer) Gd

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Char. Seutberg

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Mildred Sima

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- FEB 14 1924 ROBERT R. KRAUTER, ... Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 13 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jet 3 1924, to Jet 13 1924, that I saw h-him alive on Jet 13 24 191..., and that death occurred, on the date stated above, at 6.15a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Condition

(Coma)

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) M. D. Lee M.D.

2/13, 191.. (Address) Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL	..., 191...
20-UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

4/9

180

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83800

CERTIFICATE OF DEATH.

3 | D 83800

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Transcript

CITY OF BALTIMORE: (NO. 928 Valley ST., 10 WARD)

2-FULL NAME Mrs J. Wienzirl

(a) RESIDENCE NO. 928 Valley ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline M. Wienzirl

6 DATE OF BIRTH (month, day, and year) Oct 20-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

063

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas P. Wienzirl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Olivia Bentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Olivia Hooper

(Address) 928 Valley St

15 Filed FEB 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924, to Feb 13, 1924,

that I last saw him alive on Feb 11, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) 8 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General Phy. & Sputum

(Signed) John D Fiske M. D.

(Address) 4365 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Hill	Feb 16 1924
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83801

CERTIFICATE OF DEATH.

129 ✓

D 83801

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 E. Monument ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. B. Holden

(a) RESIDENCE NO 1015 E. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 15/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telegraph
(b) General nature of industry, business, or establishment in which employed (or employer) Operator 073
(c) Name of employer B &O

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Scanlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Peter B. Holden
(Address) 2512 Harford Ave

15 FEB 14 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb13/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial Insufficiency

(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Chr. Nephritis
(duration) yrs. mos. ds.

(Signed) J S A Dacen, M. D.
(Coroner.)
Feb14/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Feb 15 1924
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Thurber)

D 83802

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83802

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1653 Carswell ST., 9 WARD)

2-FULL NAME Smith R Thurber

(a) RESIDENCE NO. 1653 Carswell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Thurber

6 DATE OF BIRTH (month, day, and year): Mar 10-1846

7 AGE: 78 Years; 11 Months; 2 Days; If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: sea captain

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: for self

9 BIRTHPLACE (city or town) (State or country): Bayshore N y

PARENTS

10 NAME OF FATHER: Nat Rhoades

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bayshore N y

12 MAIDEN NAME OF MOTHER: Nat Rhoades

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bayshore N y

14 Informant: Catherine Thurber (Address)

15 Rec'd FEB 14 1924 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1922 to Feb 12, 1924.

that I last saw him alive on Feb 11, 1924

and that death occurred, on the date stated above, at 6.45 m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Endocarditis

About (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. L. Reinhardt M. D.

(Address) 3104 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakwood Cem Bayshore N.Y.

DATE OF BURIAL: Feb 16 1924

20 UNDERTAKER: Wm C. Miller

ADDRESS: 2334 Jefferson

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83803

D 83803

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital. ST., 7 WARD)

2-FULL NAME Gotlow Sachs.

(a) RESIDENCE NO. 2423. Eager Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white.	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Sachs

6 DATE OF BIRTH (month, day, and year) Nov 3-1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
65.	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Rebhan Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Francis Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Bintz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Josephine Sachs 2401 Eager Place

15 Filed FEB 14 1924 19 Robert F. Harrigan, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from January 3. 19 24, to Feb. 12. 19 24.

that I last saw h~~e~~ alive on Feb. 12, 19 24,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Since March from first noticed. Exp.

CONTRIBUTORY (Secondary) Myocarditis Senile (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 30

Was there an autopsy? No

What test confirmed diagnosis? P.S.S. + Gastric.

(Signed) Harold E. Pilsbury M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Feb 16 19 24

20 UNDERTAKER Chas E. Fuller ADDRESS 233 E Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83804

CERTIFICATE OF DEATH.

44 ✓ D 83804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 S. Fourth St ST., 76 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Hillt

(a) RESIDENCE No. 101 S. Fourth ST., 76 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hillt

6 DATE OF BIRTH (month, day, and year) June 4- 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Hillt 101 S. Fourth St

15 Filed ..... 1924 Albert S. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-21-23, to 2-17-1924, that I last saw her alive on 2-11-1924, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick H Herrman M. D.

(Address) 2919 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb 15 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83805

CERTIFICATE OF DEATH.

90

D 83805

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Washington Blvd ST., 21 WARD)

2-FULL NAME Nellie A. Hiltner

(a) RESIDENCE No. 1340 Washington Blvd ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hiltner

6 DATE OF BIRTH (month, day, and year) June 10. 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Rauschenbach

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Christina Nelson

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant George Hiltner
(Address) 3?? Washington Blvd.

15 Filed FEB 14 1924 Robert F. Harrigan, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1923, to Feb 12 1924.

that I last saw h.. alive on Feb 12 1924

and that death occurred, on the date stated above, at 1.29 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis,

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) C. H. Hayson, M. D.

19 (Address) 827 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb. 15 1924
20 UNDERTAKER	ADDRESS
The Mrs John H. Teufel Son	801 W. Fayette St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83806

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 So Ellwood St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Elizabeth Streckfus

(a) Residence No. 908 So Ellwood St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Sngl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 11/24

7-AGE. ....yrs. ....mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER John Streckfus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Rose Mullaney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) John Streckfus

(Address) 908 S. Ellwood Av

15- Filed FEB 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 13 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 11 1924 to Feb 13 1924

that I last saw h~~er alive~~ on Feb 13 1924

and that death occurred, on the date stated above, at 11P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Maynard E Mayer M. D

Feb 14 1924 (Address) 311 E Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Oak Lawn — DATE OF BURIAL, 2/15, 1924

20-UNDERTAKER, Philip Henig — ADDRESS 2016 Orleans St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83807

CERTIFICATE OF DEATH.

REGISTERED NO. 52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1134 Argyle Ave ST., 7 WARD)

2-FULL NAME Otha McCoy

(a) RESIDENCE No. 1134 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 1879

7 AGE: Years 27 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Petersburg Va

PARENTS

10 NAME OF FATHER: Edward McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Petersburg Va

12 MAIDEN NAME OF MOTHER: Rose McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Petersburg Va

14 Informant (Address): Kate Hawson 1134 Argyle Ave

15 FEB 14 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 13 1924

17 I HEREBY CERTIFY, That I attended deceased from FEB 2 1924, to FEB 13 1924,

that I last saw h/M alive on FEB 13 1924,

and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilated heart

(duration) x yrs. x mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 3 yrs. x mos. x ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W H Duker, M. D.

FEB 14 1924 (Address) 928 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va

DATE OF BURIAL: 2/14 1924

20 UNDERTAKER: Samuel Lansburgh & Bro

ADDRESS 328

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 83808 ✓ D 83808

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Haubert Street. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Schlordt.

(a) RESIDENCE No 1427 Haubert St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, ~~widowed, or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Charles Schlordt.

6 DATE OF BIRTH (month, day, and year) April 1, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charles Schlordt. (husband).
(Address) 1427 Haubert Street.

15 Filed FEB 14 1924 192 Robert P. Harrison, Registrar

Daniel Berrit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

Fracture of the skull and clavicle.

Accidental fall down steps.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Feb. 13th, 1924. (Address) 1014 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident in front of 1427 Haubert St.

Former or usual residence January 22, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	2/15 1924
20 UNDERTAKER Otto F. Lehmann	ADDRESS 318 Eighth St.

GE should be stated EXACTLY. PHYSICIAN should state
at it may be properly classified. Exact statement of OCCUPA-
s on back of certificate.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D 83809 2/5/24 2/6/24

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83809

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Philip Baker

(a) RESIDENCE NO. Middleburg Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 1 mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara M. Baker

6 DATE OF BIRTH (month, day, and year) May 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Farming)

(b) General nature of industry, business, or establishment in which employed (or employer) R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Middleburg
(State or country)

PARENTS

10 NAME OF FATHER John Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cornelia Miller

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Clara M. Baker
(Address) Middleburg Md.

15 Robert F. Hall (Type)
, 19 Chief Registrar

Burial Permit Issued

FEB 14 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/ 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1924, to Feb 13, 1924.

that I last saw h[illegible] alive on 1925 at 2/13/24, 1924,

and that death occurred, on the date stated above, at 7:25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid
Intestine of Long

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post Operation Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1/27/24 2/12/24

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy - Clinical Symptoms

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Carcinoma

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley Rd DATE OF BURIAL 2-15 1924

20 UNDERTAKER F. McAndrew Towson ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83810

CERTIFICATE OF DEATH.

90 D 83810

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 905 North Fulton Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Gibbs

(a) Residence No. 905 N. Fulton Ave. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Sept. 21, 1849

7-AGE. 75 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer) 068

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Cumberland, Md.

PARENTS.

10-NAME OF FATHER, James B. Gibbs

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Charlestown, S. C.

12-MAIDEN NAME OF MOTHER, Louisa Burbridge

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Cumberland, Md.

14- (Informant) Miss Louisa Gibbs

(Address) 905 N. Fulton Ave,

15- Filed [illegible] 192[illegible]

Registrar.

FEB 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 13th 1924

17- I HEREBY CERTIFY, That I attended deceased from 2 years ago, 19.... to July 13, 19 24, that I last saw h[illegible] alive on July 12, 19 24, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Own worked resting since Jan 3/24

(Duration) 4 yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gilman T. Evans, M. D.

Feb 14 1924 (Address) 833 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oakhill Cem. Wash. D. C.	2/16/24 19....
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 Calvert St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

D 83811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83811

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3627 Park Heights Ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth F. Ziegert

(a) RESIDENCE No. 3627 Park Heights ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of George Ziegert

6 DATE OF BIRTH (month, day, and year) Apr. 7. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	61	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Sommerkorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Ziegert
(Address) 3627 Park Heights ave

15 Robert P. Harrison, Registrar

EB 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1924, to Feb. 14, 1924, that I last saw her alive on Feb 13, 1924, and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver.

History of about 8 mos (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms.

(Signed) A. F. Robinson, M. D.

2/14 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feby 14 1924
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83812

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 83812

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 3 WARD)

2-FULL NAME Martin McCann

(a) RESIDENCE NO. Dont Know last place 23 S. High ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Patk McCann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Wm A Donohue
(Address) 1911 W Mulberry

15 Filed , 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

FEB 14 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. J. Fahey (Coroner.), M. D.

, 192 (Address) 1639 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	2/17 1924

20 UNDERTAKER Enge & Tarby ADDRESS Fulton & Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83813

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1504 Glenwood Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Dick

(a) Residence No. 1504 Glenwood Ave St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Dick

6-DATE OF BIRTH (month, day and year) Jan. 12-1849

7-AGE. 75 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Poole Eng. & M. Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Daniel Dick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Susan Dick

(Address) 1504 Glenwood Ave

15- Filed FEB 14 1924 Albert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 15th, 19 24, to Feb 13th, 19 24, that I last saw h.. alive on Feb 13th, 19 24, and that death occurred, on the date stated above, at 1 15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senility etc. Grippe Influenza

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. G. Miller, M. D.

(Address) 1517 Lemon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Williams & Hampden DATE OF BURIAL, Feb 16 1924

20-UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Rd.

Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83814

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 E Preston ST., 9 WARD)

2-FULL NAME Archibald T. Davis

(a) RESIDENCE No. 1406 Preston ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Catherine A. Davis

6 DATE OF BIRTH (month, day, and year) April 9, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	93	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Counselman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Richard L. Davis

(Address) 1406 Preston St.

FEB 14 1924, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1924, to Feb 14, 1924, that I last saw h in alive on Feb 14, 1924 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. Thomas, M. D.

(Address) 122 E. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrington Delaware	Feb. 16 1924
20 UNDERTAKER Robert S. Little	ADDRESS 700 Edmondson Ave

FEB 14 1924

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Boyd 602 Columbia ar

D 83815 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83815

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 832 South Paca St., 21 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Kirwan

(a) Residence No. 832 South Paca St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George W.

6-DATE OF BIRTH (month, day and year) Aug 16 1853

7-AGE, 70 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER John F Bangs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Margaret A Kramer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Dora E Bangs

(Address) 832 S Paca St

15-

Filed FEB 14 1924, Robert P. Harrison, Registrar.

Burial Permit Mark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 14/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb 14, 1924

that I last saw h. alive on Feb 12, 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Boyd, M. D.

2-42, 1924 (Address) 602 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL, 2/16, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 14 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83816

CERTIFICATE OF DEATH.

90 D 83816

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3511 Cedar Ave St. 13 Ward)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number.)

2-FULL NAME..... George A. Sentz .....

(a) Residence No. 3511 Cedar Ave St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Sentz

6-DATE OF BIRTH (month, day and year) July 8 1844

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Retired 66
(b) General nature of industry, business, or establishment in which employed (or employer) Night Watchman
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, [illegible] Sentz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER, Addy Ruby

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Carroll Co Md

14- (Informant) George A. Sentz
(Address) 3511 Cedar Ave

15- Filed 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

FEB 14 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 13 1924

17- I HEREBY CERTIFY, That I attended deceased from July, 1923 to Feb. 13, 1924
that I last saw him alive on Feb. 10 1924
and that death occurred, on the date stated above, at 7.55 m.
The CAUSE OF DEATH* was as follows:

Myocarditis, Endocarditis.

(Duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion
Arteriosclerosis.
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. H. Harrison M. D
, 19 (Address) 4037 Falls Road.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pleasant Hill DATE OF BURIAL, ..., 19....

20-UNDERTAKER, Wellman Lead & Co ADDRESS 502 E Balt

INSTRUCTIONS FOR FILLING OUT THIS CERTIFICATE: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Rigler)

D 33817

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001 D 33817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rigler

(a) RESIDENCE No. 2000 Oakley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 30-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	64	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Rigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margareth Edel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Michael Rigler (Address) 2924 E Fayette St

15 Filed FEB 14 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14-1924

17

I HEREBY CERTIFY, That I attended deceased from 1-9-, 1924, to 2-14-, 1924

that I last saw him alive on 2-14-, 1924

and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows:

Chronic Local Tuberculosis,

Strangulated Ventral Hernia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-13-24

Was there an autopsy? No

What test confirmed diagnosis? Operation findings

(Signed) H. L. Parr M. D.

2/14, 19 24 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 16 1924
20 UNDERTAKER Wm. Cook	ADDRESS 502 E 43 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2439 N. Charles St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83818

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2224 N. Charles St. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katie Thrasher Culbertson

(a) Residence No. 2224 N. Charles St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E.

6-DATE OF BIRTH (month, day and year) May 15 1862

7-AGE, 61 yrs. 9 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ga.

PARENTS.

10-NAME OF FATHER, Albert Thrasher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ga

12-MAIDEN NAME OF MOTHER, Annie Thrasher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ga.

14- (Informant) Thomas E. Culbertson

(Address) 2224 N. Charles St.

15- Filed ..... 192 .....
Registrar.

EB 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 14 1924

17- I HEREBY CERTIFY, That I attended deceased from January 14, 1924, to Feby 14, 1924, that I last saw h.. alive on Feby 13, 1924, and that death occurred, on the date stated above, at 9:35 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. 1. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Usual Physical Signs.

(Signed) H. A. Kaufman M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loraine | DATE OF BURIAL, Feb. 16 1924

20-UNDERTAKER, H. M. Cook | ADDRESS 502 E. Oliver

IN ORDER TO ASSURE A PERMANENT RECORD, EVERY ITEM SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.) (Ward) 22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Prince

(a) RESIDENCE No. 209 W. Montgomery st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) New Orleans Louisiana

PARENTS

10 NAME OF FATHER Charles Prince

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisiana

12 MAIDEN NAME OF MOTHER Eliza Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

14 Informant Hospital Records

(Address) M. T. H.

15 Filed FEB 15 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1924

17

I HEREBY CERTIFY, That I attended deceased from December 8, 1923, to Feb. 12, 1924, that I last saw him alive on Feb. 12, 1924, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. Tidaller, M. D.

2-13-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn ct	Feb 16 1924
20 UNDERTAKER	**ADDRESS**
S. S. Brown & Son	106 N. Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83820

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 83820

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1114 Schotts ct ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Aulton

(a) RESIDENCE No. 1114 Schotts ct ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Aulton

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 43 — Months: — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic (?)

(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Henry Aulton

(Address) 1114 Schotts ct

15 Filed FEB 15 1924 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/1924

17

I HEREBY CERTIFY, That I attended deceased from 2/8/24, 19.... to 2/13/24, 19.... that I last saw her alive on 2/12/24, 19.... and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

2/14/24, 19.... (Address) 908 S Shady st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct — DATE OF BURIAL: Feb-15 1924

20 UNDERTAKER: L. R. Brown & Son — ADDRESS: 108 N Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83821

CERTIFICATE OF DEATH.

100-001

D 83821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Wheeler Ave ST., 15 WARD)

2-FULL NAME Cornelia Miles

(a) RESIDENCE No. 1911 Wheeler Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Isaac H Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth A ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14

Informant Miss Purcell

(Address) 1911 Wheeler Ave

15 Filed FEB 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to Feb. 14, 1924, that I last saw her alive on Feb. 14, 1924, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Senile Type - following gradual failure of Strength)

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examinations.

(Signed) S A Dodds M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfork Va.

DATE OF BURIAL: 2/15/24 19

20 UNDERTAKER: H. E. Hughes 424 N Broadway

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 83822

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2439 Lakeview Ave. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosaltha A. James

(a) Residence No. 2439 Lakeview Ave St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Oliver C. James

6-DATE OF BIRTH (month, day and year) Nov 27. 1835

7-AGE. 88 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pa.

PARENTS.

10-NAME OF FATHER Squire Simpson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Vermont

12-MAIDEN NAME OF MOTHER, Eliza Spohr

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Vermont

14-

(Informant) Leila S. Ryer

(Address) Paris - Maine

FEB 15 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 14/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1923 to February 14 1924

that I last saw her alive on Feby 13 1924

and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) some mos. ds.

CONTRIBUTORY (Secondary) Syncope de Impenetration

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. M. Gill M. D.

Feb 4 1924 (Address) 2433 Maryland Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park DATE OF BURIAL. Feb 16 1924

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 83823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32D 83823

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 561 Bloom ST., 14 WARD)

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Smith

(a) RESIDENCE No. 561 Bloom ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4th 1905

7 AGE. Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18	3		

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John H Smith

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie L Coleman

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant John H Smith (Address) 561 Bloom St

15 FEB 15 1924 Registrar ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1924 to Feb 13 1924, that I last saw h alive on Feb 13 1924, and that death occurred, on the date stated above, at 12.35 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis (Tubercular) (duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H E Kluk, M. D.

(Address) 1 North Pk & Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 17th 1924
20 UNDERTAKER	ADDRESS
Lannon & Wright	1364 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83824

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 83824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, (No. 2103 St Paul St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sharpley Thompson

(a) Residence No. 2103 St Paul St., 17 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds How long in U. S., if of foreign birth? 72 yrs. 7 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary S. Thompson

6-DATE OF BIRTH (month, day and year) June-21-1851

7-AGE, 72 yrs. 7 mos. 23 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) Phoenix

(State or Country) Balto Co. Maryland

PARENTS.

10-NAME OF FATHER, James R. Thompson

11-BIRTHPLACE OF FATHER (city or town) Patterson

(State or Country), N. J.

12-MAIDEN NAME OF MOTHER, Jane Stugher

13-BIRTHPLACE OF MOTHER (city or town) Wales

(State or Country), Scotland

14-

(Informant) Mr. W. T. Stahlman (bro-in-law)

(Address) Roland Park City

15-

Filed FEB 15 1924 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 13-24

I HEREBY CERTIFY, That I attended deceased from February 6 1924 to Feb 13 19 24

that I last saw him alive on Feb 13 19 24

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lentz, M. D.

2-13, 194 (Address) 2040 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cemetery | DATE OF BURIAL, Feby 15 19 24

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) | ADDRESS 108 W. North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH are necessary. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83825

CERTIFICATE OF DEATH.

44 ✓

D 83825

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Teresa Selback

(a) RESIDENCE NO. 1116 N. Central Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. - mos. 9 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Joseph A. Selback

6 DATE OF BIRTH (month, day, and year) Feb. 4 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	-	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Brockmeyer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Degenhardt

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr Joseph A. Selback
(Address) 1116 N. Central Ave

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

FEB 15 1924

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1924, to Feb. 14, 1924, that I last saw her alive on Feb. 14, 1924 and that death occurred, on the date stated above, at 12 05 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver (metastatic)
Peritoneal Adhesions
Pneumonia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Jno A Gouspeland, M. D.

. 19 (Address) M D Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemy	Feb 18 1924
UNDERTAKER	ADDRESS
Henry Storck Son	1201 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83826

CERTIFICATE OF DEATH.

71-006 D 83826

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 2 WARD)

2-FULL NAME Joseph Krulicki

(a) RESIDENCE NO 931 Fell St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zuzane Krulicki

6 DATE OF BIRTH (month, day, and year) Feb 12/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Peter Krulicki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Wisniewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Zuzane Krulicki
(Address) 931 Fell St

15 Filed FEB 15 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1923/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Purulent Meningitis
(Probably Streptococcus Infection, no autopsy allowed)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Mackenzie, M. D.
(Coroner.)

Feb 14 24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Feb 16 1924

20 UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

D 83827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83827

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2305 Oak St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Gertude Mason

(Residence in Baltimore: No. 2305 Oak St. St.; yrs. 10 mos. ds.)

Lives in Balto 10 yrs

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	colored	married

6-DATE OF BIRTH. 1891
(Month) (Day) (Year)

7-AGE. 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. James Wiggins

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Hannah Drummond

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane G mason

(Address) 2305 oak St

15- FEB 15 1924 ROBERT R. KRAUTER, Registrar.

Buried

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 13, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to *his death on the day stated above.

The CAUSE OF DEATH was as follows:

Pulmonar
Disease of
Heart 6
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John H. Morrison M. D.
(Coroner.)

Feb 14 1924 (Address) 3632 Roland Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mns. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Manchock Md — DATE OF BURIAL, Feb 15 1924

20-UNDERTAKER, Joseph a Farrell — ADDRESS, 2319 Division St

N. B.—Every item of information should be carefully supplied and stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83828 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 83828

CERTIFICATE OF DEATH.

5 160

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 607 N Eutaw St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Dean,

(a) Residence No. 607 N. Eutaw St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 11-1923

7-AGE. X yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) Balto
(State or Country),

PARENTS.

10-NAME OF FATHER Leon Dean

11-BIRTHPLACE OF FATHER (city or town) Brunswick Md
(State or Country)

12-MAIDEN NAME OF MOTHER, Mary Chaney

13-BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or Country),

14- (Informant) Leon Dean
(Address) 607 N Eutaw,

15- Filed FEB 15 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 14-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1923 to Feby 14 1924, that I last saw h[illegible] alive on Feby 13 1924, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Nephritis.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert H. Levy M. D.

2/14/1924 (Address) 1735 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Feby 16 1924

20-UNDERTAKER: John Ulrich — ADDRESS: 2008 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

Nichola Fiorentino

D 83829

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83829

[redacted]ICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 707 W Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicola Fiorentino

(a) Residence No. 707 W Lexington St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Clementina Fiorentino

6-DATE OF BIRTH (month, day and year) Mar 6-1868

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or. mts.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Angelo Fiorentino

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Dora Russo

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14- (Informant) Angelo Fiorentino

(Address) 707 W Lexington

15- Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2/14/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1923 to Feb. 14 1924

that I last saw h. alive on Feb. 14 1924

and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. Artigiani M. D.

, 19 (Address) 2942 E. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	Feby 16 1924
20-UNDERTAKER. John Ellis	ADDRESS 207 E Eden

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N. Carrollton Ave ST.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roseane Althoff

(a) RESIDENCE. No. 204 N. Carrollton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Althoff

6 DATE OF BIRTH (month, day, and year) July 21 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Guthruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Terry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Zahrendt
(Address) 213 N. Carrollton Ave

Filed FEB 15 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923, to Feb 12, 1924, that I last saw her alive on Feb 12, 1924, and that death occurred, on the date stated above, at 11-8 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) ✓ yrs. ✓ mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis,

(duration) Over 6 mos.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis? Henry A Foltz M. D.

(Signed) (Address) 1203 N. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 15 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins st

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83831

CERTIFICATE OF DEATH.

N4 D 83831

1-PLACE OF DEATH

City of BALTIMORE: (No. 3300 Magnolia Ave St. Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret India Butler

(a) Residence No. 3300 Magnolia Ave St. Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Butler

6-DATE OF BIRTH (month, day and year) Aug 22, 1857

7-AGE. 67 yrs. 5 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frederick Butler

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Balto

12-MAIDEN NAME OF MOTHER, Louisa Butler

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Balto

14-
(Informant) John G. Butler

(Address) 3300 Magnolia Ave

15-
Filed FEB 15 1924 By ROBERT H. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 19 24, to Feb 2 19 24

that I last saw h. alive on Feb 1 2 19 24

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

Myocardial Insufficiency

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Chas Emmons, M. D.

2/12, 19 24 (Address) 4706 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood — DATE OF BURIAL, Feb 15, 1924

20-UNDERTAKER, Jno Cook — ADDRESS 502 E Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83832 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83832

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2325 Eastern Ave ST. 26 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leopold Ramsel

(a) RESIDENCE. No. 2325 Eastern Ave. ST.... WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa Ramsel
6 DATE OF BIRTH (month, day, and year): J. 7. 74.
7 AGE: Years 79 Months 5 Days 7. If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Bookkeeper.
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country): Meiden Germany

PARENTS
10 NAME OF FATHER: Leopold Ramsel
11 BIRTHPLACE OF FATHER (city or town) (State or country): Meiden Germany
12 MAIDEN NAME OF MOTHER: Hartmann
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant: Mrs Minnie Ramsel
(Address) 2325 Eastern Ave.

FEB 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): J. 14. 1924
17 I HEREBY CERTIFY, That I attended deceased from Dec. 5th 1923 to Feb. 14th 1924
that I last saw him alive on Feb. 13th 1924
and that death occurred, on the date stated above, at 1:10 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Hemiplegia
(duration) 2 yrs. 2 mos. 8 ds.
(INTERMEDIATE) Senility
(duration) yrs. mos. 1 ds.
(PRIMARY) Arteriosclerosis
18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Louis A. Mayer M.D.
1924 (Address) 1831 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Feb. 17 1924
20 UNDERTAKER: L. Freeman — ADDRESS: 321 Bond

NOTE—THE FACTS, WITH REGARD TO THE DECEASED, CALLED FOR IN THIS CERTIFICATE, MUST BE CAREFULLY OBTAINED. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 D 83833 (1936)

CERTIFICATE OF DEATH.

D 83833

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 19 WARD)

2-FULL NAME Alberta Faulkner

(a) RESIDENCE No. 916 N Stricker St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 5 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer) H

(c) Name of employer H

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathan Faulkner

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Anny Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Reynolds JOHNS HOPKINS HOSPITAL (Address)

15 Filed FEB 15 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Feb 14, 1924.

that I last saw h[illegible] alive on Feb 14, 1924.

and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

Pneumococcus conjunctivitis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Vomiting & diarrhoea

(duration) 0 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscope

(Signed) H. A. Weech M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Cemetery	Feb 16, 19
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	716 N. Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83834 CERTIFICATE OF DEATH. D 83834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Miller

(a) RESIDENCE No. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1829

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	95			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1918 to Feb. 12, 1924, that I last saw him alive on February 11, 1924, and that death occurred, on the date stated above, at 4:40 A.M. The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext

(Signed) Clarence A. Ibrey, M. D.

2-13-24 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health.

ADDRESS

FEB 15 1924

Per Wm. E. WOODALL

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83835 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 83835

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 Harlem Avenue St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Anton Imwold

(a) Residence No. 1603 Harlem Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie A. Imwold

6-DATE OF BIRTH (month, day and year) Oct 29 1847

7-AGE.	If LESS than 1 day,
76 yrs. 3 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. John Imwold

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Catherine Welkner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mrs. Carrie A. Imwold

(Address) 1603 Harlem Avenue

Filed FEB 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from 12 Feb 1924 to 13 Feby 1924

that I last saw h. alive on Feby 13 1924

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. 19 hours ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 1 hour ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas R Waters M. D.

2-14-1924 (Address) 2108 Brookfield Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oakwood	Feb 16, 1924
20-UNDERTAKER.	ADDRESS
Jos B Cook	1003 N Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83836 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83836

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Elgin Ave. Evergreen St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Witmyer

(a) Residence No. Elgin Ave. Evergreen St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine H. Witmyer

6-DATE OF BIRTH (month, day and year) Oct. 24, 1841

7-AGE. 82 yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carriage Smith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hanover

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, John Witmyer

11-BIRTHPLACE OF FATHER (city or town) Dolphin (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Susie Myer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) Mrs. Catherine H. Witmyer

(Address) Elgin Ave. Evergreen

15- Filed FEB 15 1924 19 ROBERT H. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 14, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 30th 1924 to Febuary 14th 1924 that I last saw him alive on Feb. 12th 1924 and that death occurred, on the date stated above, at 12.10 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Albert C. Reiby M. D.

2-15 1924 (Address) 2734 Penna. Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lauden Park Cem	Feb 18, 1924
20-UNDERTAKER,	ADDRESS
Jos B Cook.	1008 W Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83837

CERTIFICATE OF DEATH.

129 D 83837

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 N Broadford ST.: 8 WARD)

2-FULL NAME Mary Eva Emig

(a) RESIDENCE. NO. 1627 N Broadford ST., 8 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Adam Emig

6 DATE OF BIRTH (month, day, and year) July 28 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81	81	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Leonard Orch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz Kraus.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Jane A. Miller

(Address) 1915 Broadway St

15 FEB 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1923, to Feb 14, 1924, that I last saw her alive on Feb 13, 1924, and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D P Herzog MD, M. D.

2/15, 1924 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	Feb 15 1924

20 UNDERTAKER	ADDRESS
Harry H. Weitzke	1531 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83838

CERTIFICATE OF DEATH.

D 83838

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers Hospital ST.: 4 WARD) 101-061

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miles Newman

(a) RESIDENCE. NO. 643 W. Fayette ST., WARD. 9a

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15

FEB 15 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 5, 1924, to Feb. 14, 1924, that I last saw him alive on Feb. 13, 1924, and that death occurred, on the date stated above, at 4:40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Left Lung to Pleura

(duration) yrs. 9 mos. ~~11~~ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical signs

(Signed) Wm. R. Johnson, M. D.

2/14, 1924 (Address) 120 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery DATE OF BURIAL: Feb 16 24

20 UNDERTAKER: Harry H. Weitzke ADDRESS: 153 W. Lemmon

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83839

CERTIFICATE OF DEATH

44 D 83839

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hosp.

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

2-FULL NAME Mr Isaac D. Wheaton

(a) RESIDENCE NO. 803 Pennington Ave ST. Curtis Bay WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. 27 ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Mary Croll

6 DATE OF BIRTH (month, day, and year) March 17 1843

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Notary

(b) General nature of industry, business, or establishment in which employed (or employer) Public

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10 NAME OF FATHER John Wheaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Celia Dexter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nova Scotia

14 Informant Patient

(Address)

15 Dec FEB 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1924, to Feb. 14, 1924, that I last saw him alive on Feb. 14, 1924, and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Disease (Carcinoma)

Metastases to Liver

Gastral Carcinatosis

Chronic Myo + Endo Carditis

Arterio Sclerosis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) Jno A Lowe Jones M. D.

, 19 (Address) Mt Hope Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Feb 15 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83840 ✓ D 83840

CERTIFICATE OF DEATH.

D 83840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3810 Chatham Road ST., 15 WARD)

REGISTERED NO. 76

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Mitchell

(a) RESIDENCE No. 3810 Chatham Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa I. Mitchell

6 DATE OF BIRTH (month, day, and year) Nov. 12 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	69	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in Paints &

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rosa I. Mitchell (wife)

(Address) 3810 Chatham Road

Filed FEB 15 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1924, to July 14th, 1924, that I last saw him alive on July 13th, 1924, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs.

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Pernicia

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physicians

(Signed) N. H. Dwyer, M.D.

, 19 (Address) 1341 Clarco

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Feb 16 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Lights

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83841

CERTIFICATE OF DEATH.

101-001 ✓ D 83841

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Fredericka ST., 20 WARD)

2-FULL NAME Henry Leroy Eberling

(a) RESIDENCE NO. 3142 Fredericka Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 4 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/14/1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John J Eberling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katherine Tibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Eberling
(Address) 3142 Fredk Ave

FEB 15 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1924

17

I HEREBY CERTIFY, That I attended deceased from 2/9 . 1924 . to 2/13 . 1924.

that I last saw him alive on 2/13 . 1924.

and that death occurred, on the date stated above, at 9:20 m.

The CAUSE OF DEATH* was as follows:

Influenza with a Lobar pneumonia with an involvement of left lobe

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death? 3142 Fredk Ave

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) D F Alexander, M. D.

. 19 (Address) 3316 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb. 16 1924

20 UNDERTAKER L. W. Dill — ADDRESS 3109 Fredk. Ave.

MARRIAGE LICENSE, WITH OFFICIAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83842

CERTIFICATE OF DEATH.

43 D 83842

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 E Chase ST. 10 WARD)

2-FULL NAME Winfield Scott Canby

(a) RESIDENCE No. 615 E. Chase ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Canby

6 DATE OF BIRTH (month, day, and year) April 25 186[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 061

(b) General nature of industry, business, or establishment in which employed (or employer) Detective

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thos. Canby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna V Carrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anne E Canby

(Address) 615 E Chase St

B 15 1924

Filed ..... 19..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1920, to Feb 14, 1924, that I last saw h[illegible] alive on Feb 14, 1924, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Sub-Maxillary Glands & Cervical Glands

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

2-14 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Feb 18 1924

20 UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Greenmt Av

NOTE—WRITE PLAINLY, WITH INDELIBLE PENCIL OR PEN AND INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83843

CERTIFICATE OF DEATH.

74-001 D 83843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 E Biddle ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs J Harris

(a) RESIDENCE NO. 929 E. Biddle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Harris

6 DATE OF BIRTH (month, day, and year) June 9—

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jos Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Harris
(Address) 929 E. Biddle St.

15 Filed FEB 5 1924, 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14 1924

17 I HEREBY CERTIFY, That I attended deceased from February 13, 1924, to February 13, 1924, that I last saw h[illegible] alive on February 13, 1924, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 1 dy

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. ..... mos. 2 dys

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Robinson, M. D.

, 19 (Address) 712 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md | DATE OF BURIAL Feb 16 1924

20 UNDERTAKER H. C. Wiedefeld | ADDRESS 914 Fremont Ave

WHEN FILLED, WRITE CAREFULLY IN INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Seals)

D 83844

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-9½ ✓ 83844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1615 Latrobe ST., (Ward) 12

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dearlo

(a) RESIDENCE NO. 1616 Latrobe ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — — —

6 DATE OF BIRTH (month, day, and year) Jan 31 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) — None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas. Dearlo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Beatrice Tait

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Chas. Dearlo.

(Address) 1615 Latrobe St.

15 ..... 19 ..... Robert T. Harrison, Registrar

FEB 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924 to Feb 12, 1924

that I last saw him alive on Feb 12, 1924

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley M. D.

2/14. 1924 (Address) 1238 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional data.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery DATE OF BURIAL: Feb 15 1924

20 UNDERTAKER: MacRae Elliott ADDRESS: 1225 Carlton

D 83845 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83845

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 318 N Monroe St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas W. Quirk

(Residence in Baltimore: No. 318 N Monroe St.; yrs. 45 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mal

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. August 15 1877 (Month) (Day) (Year)

7-AGE. 52 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paint Detective
(b) General nature of Industry, business, or establishment in which employed (or employer): Public Dept. 06

9-BIRTHPLACE, (State or Country). Harve de Grace

PARENTS.

10-NAME OF FATHER, Dennis Quirk

11-BIRTHPLACE OF FATHER, (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Margaret Hollahan

13-BIRTHPLACE OF MOTHER, (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas J. Quirk

(Address) Harve De Grace Md

15- Filed FEB 15 1924 192 Robert F. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 13 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(Duration) yrs.

(Signed) James M Kemler M. D. (Coroner)

2-13-, 1924 (Address) 707 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Catholic Cemetery	Feb 16 1924

20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	1811 N Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

D 83846

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-09 ✓ 83846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 E. 20th ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia M. Finn

(a) RESIDENCE NO. 720 E. 20th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander C. Finn

6 DATE OF BIRTH (month, day, and year): Nov 5-1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Jane Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Mary Finkbeil 1417 N. Caroline St.

15 FEB 15 1924 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 11th 1924 to Feb 14th 1924, that I last saw her alive on Feb 13th 1924, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) P. E. Filby, M. D.

Feb 15 1924 (Address) 5 W. E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 2/18 1924

20 UNDERTAKER: Chas P. Hamilton — ADDRESS: 1811 W. Royal Ave

BE WRITTEN PLAINLY, WITH UNFADING INK. THIS BLANK MUST NOT BE FOLDED. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83847

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D 83847

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 N. Bond ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Huber

(a) RESIDENCE No 1313 N.Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Huber

6 DATE OF BIRTH (month, day, and year) Nov--1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer) Underwear

(c) Name of employer Factory

086

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robt. L. Huber

(Address) 1626 E. Preston St

15 Filed ....., 192 Robert P. Mayfield, Registrar

FEB 15 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

(Accidental-leky gas fixture)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. McCollum, M. D.

(Coroner.)

Feb 15/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 2/16 24 192

20 UNDERTAKER Geo. J. Roth

ADDRESS 1936 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83848

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 832 S. Paca St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John F. Bangs .....

(a) Residence No. 832 S. Paca St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Bangs

6-DATE OF BIRTH (month, day and year) May 17

7-AGE. 74 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brush Maker

(b) General nature of Industry, business, or establishment in which employed (or employer) Packer

(c) Name of employer Lehn & Co

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER. John F. Bangs

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER. Margaret A. Kramer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Annie E. Bangs

(Address) 832 S. Paca St

15- Filed FEB 15 1924 192..... Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 15/24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 28, 24, to Feb. 15, 24, that I last saw h. alive on Feb. 14, 24, and that death occurred, on the date stated above, at 5.45 a. m. The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Henry Boyd M. D

Feb. 15, 1924 (Address) 602 Wash. Blvd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem't | DATE OF BURIAL. Feb 18 1924

20-UNDERTAKER. William Cook | ADDRESS 602 E. North Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83849

CERTIFICATE OF DEATH.

D 83849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 397 Evesham Ave ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Anne Vain

(a) RESIDENCE NO. 397 Evesham Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 23 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18 1924

7 AGE — Years | Months | Days: 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry E. Vain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie M. Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Harry E. Vain
(Address) 397 Evesham Ave

15 Filed ..... 19 .....
Robert F. Harrison,
Burial Permit Clerk.
Registrar

FEB 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 14, 1924, to Feby 14, 1924, that I last saw her alive on Feby 14, 1924, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart trouble

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature birth

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. L. Duncan, M. D.

(Address) 6104 York Road Feby 15 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem

DATE OF BURIAL: Feb 16 1924

20 UNDERTAKER: Jos Joerdens & Son

ADDRESS 2178 Rm

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83850

CERTIFICATE OF DEATH.

38 D 83850

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Crawford Hinton

(a) RESIDENCE NO. 622 Rabow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Hinton

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 53; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER Peter Hinton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Laura Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant (Address): Friends.

15 Filed FEB 15 1924 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/24 19

17 I HEREBY CERTIFY, That I attended deceased from 1/17/24, 19, to 2/13/24. 19.

that I last saw him alive on 2/13/24. 19

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

Aortic Insufficiency

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Staphylococcus Septicemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Thompson M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 15 1924

20 UNDERTAKER: Commissioner of Health.

Per Wm. E. WOODALL

ADDRESS

FEB 15 1924

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE should
t it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

(Wozniak)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83851

CERTIFICATE OF DEATH.

31

D 83851

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2004 Fleet St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Wozniak

(a) Residence No. 2004 Fleet St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Wozniak

6-DATE OF BIRTH (month, day and year) Sept 23 1883

7-AGE 37 yrs. 5 mos. ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland Baltic

PARENTS.

10-NAME OF FATHER, Bartholomew

11-BIRTHPLACE OF FATHER (City or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Krasnowska

13-BIRTHPLACE OF MOTHER (City or town) (State or Country), Poland

14- (Informant) Frank Wozniak

(Address) 2004 Fleet St

15- Robert P. Harrison Registrar.

FEB 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 13-24

17- I HEREBY CERTIFY, That I attended deceased from Feb 3- 1924 to Feb 13- 1924

that I last saw h- alive on Feb 13- 1924

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2-3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Grave & Cerebr

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Mabel Bowler M. D.

, 19 (Address) 125 S Bway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary DATE OF BURIAL. Feb 15, 1924

20-UNDERTAKER. J W Ozgueski ADDRESS 1930 Eastern

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83852

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 Mc Elderry St. ST., 7 WARD)

2-FULL NAME Vincenz Stadler

(a) RESIDENCE NO. 1927 Mc Elderry St ST., 7 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Stadler

6 DATE OF BIRTH (month, day, and year) Sept 15- 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Alexander Stadler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Joseph Stadler (Son)
(Address) 1927 Mc Elderry St.

15 Robert F. Harrison, ...19.....
Registrar

B 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to Feb 12, 1924, that I last saw h[illegible] alive on Feb 10 1924 and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis (Interstitial)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Tilney M. D.

2/13 1924 (Address) 6 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Feb. 16 1924

20 UNDERTAKER Lilly and Zeiler. ADDRESS 403 S Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Q[illegible] OPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83853

CERTIFICATE OF DEATH.

138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. May Stern

(a) RESIDENCE NO. 3040 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~HUSBAND OF~~ WIFE of Jacob Stern

6 DATE OF BIRTH (month, day, and year) 12/5/1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ellis Preston.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford. County.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant (Address) Jacob Stern 3040 Edmondson.

15 Filed APR 15 1924 16 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1924, to Feb 14, 1924, that I last saw her alive on Feb 14, 1924, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Over

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 13, 1924

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) A. A. Susbman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem. DATE OF BURIAL Feb 17 1924

20 UNDERTAKER George J. Ruth 1735 Harford Ave ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83854

CERTIFICATE OF DEATH.

D 83854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Brentwood Ave. WARD 10)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Louis Krause

(a) RESIDENCE No. 1032 Brentwood Ave. WARD 10
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 12-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Rudolph E. Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma J. Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rudolph E. Krause
(Address) 1032 Brentwood Av

15 Filed FEB 15 1924, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14- 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1924, to Feb. 14, 1924, that I last saw him alive on Feb. 14, 1924, and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) (Flu)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Edwin B. Fenby, M. D.

2/15/1924 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	2/16/24

20 UNDERTAKER Geo. J. Rutt ADDRESS 1735 Hoffman Ave.

Burial Permit Clerk.

P.S.—WRITE PLAINLY, WITH INDELIBLE PENCIL OR PEN AND INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83855 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 83855

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2241 Preston Place ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Martine

(a) RESIDENCE NO 2241 Preston Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) July 17/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer) Home Medicines
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant John Edw. Greenbeck
(Address) Raspburg Md.

15 FEB 15 1924 192 Robert P. Harris Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilitation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia (probably) new

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Vallen, M. D.
(Coroner)

Feb 15/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Feb. 16 1924
20 UNDERTAKER	ADDRESS
Pratt Lassahn Sons	Fullerton

CAUSE OF DEATH must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83856

CERTIFICATE OF DEATH.

31 D 83856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 E. Hughes ST., 27 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Jenkins

(a) RESIDENCE NO. 135 E. Hughes ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 9, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of Industry, business, or establishment in which employed (or employer) 686

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Jenkins

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Finn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Mary Jenkins
(Address) 135 E Hughes St

15 Filed ..... Robert F. Harrison. Registrar

FEB 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.15 1924

17 I HEREBY CERTIFY, That I attended deceased from 11. 1. 23, 19..... to 2.15.24, 19.....

that I last saw her alive on 2.14.24, 19.....

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
dont know.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) myocarditis
(duration) dont know yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

2.15. 1924 (Signed) J. Edward Norris, M. D.
(Address) 107 E. west st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 2-18 1924

20 UNDERTAKER Margaret E. Flynn

ADDRESS 147 W Lafayette

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 83857

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 N 83857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 Clarkson ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Murray

(a) RESIDENCE NO. 1538 Clarkson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21-1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
23	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street Car Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) U. R. W. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER John J. Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Jo Fallon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Jno. J. Murray

(Address) 1538 Clarkson St.

15 Filed ..... 19.. Robert P. Harrison, Registrar

FEB 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14. 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1922, to Feb 14, 1924, that I last saw him alive on Feb 13—, 1924, and that death occurred, on the date stated above, at 5- P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) C. E. Buxton, M. D.

2/16, 1924 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Feb. 15 1924
20 UNDERTAKER Margaret E. Flynn	ADDRESS 1422 Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S sold state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83858

D 83858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1509 Myrtle Ave ....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jones

(a) Residence No. 1509 Myrtle Ave .....Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Francis Jones.

6-DATE OF BIRTH (month, day and year) May 1842

7-AGE. 81 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John T. Burnham

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth A. Norris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs. Judd Stevens

(Address) 2120 Maryton

15- Filed ..... 1924 Robert F. Harrison, Registrar.

B 1 6 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 1924 to Feb 14 1924

that I last saw h.. alive on Feb 13 1924

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. Gilstant M. D

2-14 1924 (Address) 41 N. Lauren

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olive Cem. DATE OF BURIAL. Feb 16 1924

20-UNDERTAKER. W. H. Tuckerman ADDRESS North & Pa

EXACTLY. PHYSICIANS should state CAUSE OF DEATH Exact statement of OCCUPATION is very important. Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 619 Conway St., 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Pursley

(a) Residence No. 619 Conway St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ HELEN M. DAVIS, DECEASED

6-DATE OF BIRTH (month, day and year) Aug 11th 1873

7-AGE, 50 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer /

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James H Pursley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary N McCloskey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs. James H Pursley

(Address) 619 Conway St

15- Robert P. Harrison, M.D.

Registrar.

B 161924

Asst Chief Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby 13 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15. 1923 to Feb. 13. 1924.

that I last saw him alive on Feb. 13. 1924.

and that death occurred, on the date stated above, at 3.45 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Thos Jenkins, M. D.

2/15/24 (Address) 888 W. Lombard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Febry 16 1924
20-UNDERTAKER,	ADDRESS
John J Conway & Son	619 Conway St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S·A·E

OODAK

Spec.—1-10-21 M&T 1500 Bks.

D 83860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 83860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Scott ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Mills

(a) RESIDENCE NO. 606 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. John R. Mills

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	71	2	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know.

14 Informant Margaret J. Hayes. (Address) 606 Scott St.

15 Filed Robert P. Harrison, Registrar

B 1 6 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924 to Feb 15 1924

that I last saw h-e alive on 2-15 1924

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch. Int. Nephr.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) John T. Gilmore M.D.

, 19 (Address) 11 Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Feb 19. 1924

20 UNDERTAKER Mr & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83861

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83861

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter J. Jenkins

(a) RESIDENCE No. 113 S. Carrollst ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Jenkins

6 DATE OF BIRTH (month, day, and year) Jan 1. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Margaret A. Jenkins

(Address) 1133 Carroll St

15 Filed Robert J. Norris, Registrar

B 16 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1924, to Feb 14th, 1924, that I last saw him alive on Feb 14th, 1924 and that death occurred, on the date stated above, at 6.39 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchs. Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen. Exam. & Laboratory

(Signed) [redacted], M. D.

, 19 (Address) 1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 18 1924

20 UNDERTAKER Mc Nus. J. W. Teufel & Son — ADDRESS 801 W. Fayette

P. S.—WRITE PLAINLY, WITH UNFADING INK. EVERY mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83862

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N. Lee ST., 27 WARD)

2-FULL NAME Eliza Blackville

(a) RESIDENCE NO. 501 N. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. Blackville

6 DATE OF BIRTH (month, day, and year) [illegible] 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER James Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jas. Blackville

(Address) 501 N. Lee St.

15 Feb 16 1924 Robert F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12/1924

17 I HEREBY CERTIFY That I attended deceased from Jan. 1, 1924, to Feb. 12, 1924, that I last saw him alive on Feb. 12, 1924, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

2/17, 1924 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Feb. 17 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Uniel St

N.B. WRITE LEGIBLY. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 - M&T - 1500 Blks.

D 83863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83863

100-001

CERTIFICATE OF DEATH.

8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 North Duncan ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Philip Hoffman

(a) RESIDENCE NO. 1820 North Duncan ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Henry Hoffman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Jenny Gatton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant John Henry Hoffman
(Address) 1820 North Duncan

15 Filed FEB 16 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14th 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1924, to Feb 13, 1924, that I last saw h— alive on Feb 13, 1924, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Edw A Blanson, M. D.

Feb 14, 1924 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Wilkinsville	2/16/24
20 UNDERTAKER	ADDRESS
Gr. Weber & Son	2503 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83864 HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D 83864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1846 N. Gay St. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frederick H. Haseidel

(a) Residence No. 1846 N. Gay St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Haseidel

6-DATE OF BIRTH (month, day and year) Oct 21-1860

7-AGE. 63 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Janitor
(b) General nature of Industry, business, or establishment in which employed (or employer). 086
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Catherine Haseidel
(Address) 1846 N. Gay St.

15- FEB 16 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 9, 1924 to Feby 14 1924

that I last saw him alive on Feby 14 1924

and that death occurred, on the date stated above, at 2-45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza.

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Magruder M. D.

. 19 (Address) 14 E. Fort Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	Feb. 18 1924
20-UNDERTAKER.	ADDRESS
Josiah Lyfer	1800 W. Pratt

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83865

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-02 D 83865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Swabaugh.

(a) RESIDENCE No. 720 N. 34th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Swabaugh

6 DATE OF BIRTH (month, day, and year) Oct 28 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Swabaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Polesha Yengling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hospital Records (Address)

15 Filed ..... 19 ..... Robert T. Mathieu, Registrar

FEB 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1924, to Feb. 15, 1924, that I last saw h[illegible] alive on Feb 15, 1924, and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction due to Volvulus

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Feb 12, 1924

Was there an autopsy?

What test confirmed diagnosis? Clinical & Operative findings

(Signed) Carl A. Newcomb, M. D.

Feb 15, 1924 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Feb 18 1924

20 UNDERTAKER T. S. Marshall ADDRESS 1539 Fall Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 83866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Falls Road ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Bell Watts

(a) RESIDENCE. No. 1015 Falls Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Eugene R. Watts

6 DATE OF BIRTH (month, day, and year) May 7-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Robt F. Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Emma Gregg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Eugene R. Watts

(Address) 1015 Falls Rd

15 Filed ..... 19 Robert F. Harrison, Registrar

FEB 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1923, to Feb 15, 1924, that I last saw h.. alive on Feb 15, 1924, and that death occurred, on the date stated above, at 10:45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma —

Sigmoid - Recurred

Liver (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Kidneys, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 12, 23

Was there an autopsy? No

What test confirmed diagnosis? Excision - Microscopic

(Signed) Paul Steinmeller, M. D.

2/15, 1924 (Address) 327 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Stampers	Feb 19 19

20 UNDERTAKER	ADDRESS
A. S. Marshall	3539 Falls Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83867

CERTIFICATE OF DEATH.

43 D 83867

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 W 38th St. 813 WARD)

2-FULL NAME Lewis A. Schaum

(a) RESIDENCE NO. 912 W 38th St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

AGE should be stated EXACTLY. PHYSICIAN should state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schaum

6 DATE OF BIRTH (month, day, and year) Nov 18 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
71	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Joe James

(Address) 912 W 38th St

15

Filed ..... Robert P. Harrison, Registrar

EB 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1923, to Feby 14, 1924, that I last saw h.im alive on Feby 14, 1924, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of rectum.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Examination.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

2/6, 1924 (Address) 434 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park

DATE OF BURIAL Feb 16 1924

20 UNDERTAKER CHENOWETH & SON

ADDRESS 3617 CHESTNUT AVE

Spec.—1-10-21—M&T—1500 Bks.

D 83868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83868

CERTIFICATE OF DEATH.

93

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd & Calvert ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Rathbone

(a) RESIDENCE No. 315 W. 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida V Rathbone

6 DATE OF BIRTH (month, day, and year) March 5, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Rathbone

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant: W W. Rathbone (Address) 315 W 30th St. Balt.

15 Filed FEB 16 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1924, to Feb 15, 1924,

that I last saw him alive on Feb 15, 1924,

and that death occurred, on the date stated above, at 1.27 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

(duration) yrs. mos. 4/24 ds.

CONTRIBUTORY (Secondary) Phlebitis

(duration) yrs. mos. 7 ds.?

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) A B Price, M. D.

2/15/24 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb 18 1924

20 UNDERTAKER: GHENOWETH & SON — ADDRESS: 2617 CHESTNUT AVE.

AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1294 D 83869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Poole St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Switzer

(a) RESIDENCE No. 3510 Poole St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late George R Switzer

6 DATE OF BIRTH (month, day, and year): Dec 22 1858

7 AGE: Years 65 Months 1 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Daisy Sheckells

(Address): 3510 Poole St.

15 Filed ..... 19 Robert P. Harrison Registrar

FEB 16 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1924, to Feb. 14, 1924, that I last saw h-e alive on Feb 14, 1924, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. Heyl Cook M. D.

2-15, 1924 (Address) 3701 Fleet Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: Feb 18 1924

20 UNDERTAKER: CRENOWETH & SON,

ADDRESS: 2617 CHESTNUT AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83870

D 83870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 19 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno Evans.

(a) RESIDENCE NO. 505 N. Gilmor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Evans

6 DATE OF BIRTH (month, day, and year) May 10, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) 0'21
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS
10 NAME OF FATHER John Evans
11 BIRTHPLACE OF FATHER (city or town) Accomac Co. (State or country) Virginia
12 MAIDEN NAME OF MOTHER Lettie Evans
13 BIRTHPLACE OF MOTHER (city or town) Accomac Co. (State or country) Virginia

14 Informant (Address) Mrs. Anna Evans 505 N. Gilmor St.

15 FEB 16 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1924, to Feb 14, 1924, that I last saw alive on Feb 14, 1924, and that death occurred, on the date stated above, at 1.55 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G. Schwenge, M. D.

, 19 (Address) St Joseph's Hosp,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 16 1924.

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83871

188-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. (St.) 8 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H. Bischoff.

(a) RESIDENCE NO. 2921 Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bischoff.

6 DATE OF BIRTH (month, day, and year) Sept 23-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk Dept
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER H. F. Bischoff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elizabeth Bischoff
(Address) 2921 Wilson Ave

Filed FEB 16 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Accident

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. ds.

(Signed) Geo E Blades, M. D.
(Coroner)

, 192 (Address) 436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb 16 1924

20 UNDERTAKER F. B. Keyser ADDRESS 2256 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EB 16 1924

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83872

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 521 W. West St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE. NO. 521 W. West ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mallan Brown

6 DATE OF BIRTH (month, day, and year) July 11 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 yrs.	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) House maid

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Alfred Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Susie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Joseph Hughes
(Address) 521 W. West St.

15 Filed FEB 16 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1924, to Feb. 14, 1924, that I last saw h. alive on Feb. 13, 1924, and that death occurred, on the date stated above, at 3, 15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam.

(Signed) J. L. Shelton, M. D.

2/14, 1924 (Address) 203 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odenton Md	2/17 1924

20 UNDERTAKER J. A. Skinner ADDRESS 620 E. Read St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 129 D 83873

1-PLACE OF DEATH

City of BALTIMORE: (No. 3315 Westerwald Ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Smith

(a) Residence No. 3315 Westerwald Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alfred Smith

6-DATE OF BIRTH (month, day and year) Dec 8 1849

7-AGE. 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... not any

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pa

PARENTS:

10-NAME OF FATHER Christopher Schappler

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country),

13- (Informant) Margaret L Rivard

(Address) 3315 Westwald ave

15- Robert F. Harrison, Registrar.

FEB 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2.14.24.

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1924, to date of death

that I last saw h.. alive on 2.13.24 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Death due to Interstitial Nephritis of indefinite duration.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chauncey Le Davis M. D

2.14. 1924 (Address) 814 N. Wolfe ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem

DATE OF BURIAL. Feb. 16. 1924

20-UNDERTAKER. John O. Mitchell

ADDRESS 1201 W Fayette St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83874 D 83874

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Jasper ST., 17 WARD)

2-FULL NAME Charles Simpson

(a) RESIDENCE NO. 525 Jasper ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. 3 mos ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ... Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER James Simpson

11 BIRTHPLACE OF FATHER (city or town) Chas. Co.
(State or country) Md

12 MAIDEN NAME OF MOTHER Mattie Stepson

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Mattie Simpson
(Address) 525 Jasper St

15 FEB 16 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14. 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9. 1924, to Feb 14. 1924, that I last saw him alive on Feb 13 1924, and that death occurred, on the date stated above, at 10:55 P. m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) 1 yrs. ... mos 5 ds?
CONTRIBUTORY (Secondary) Whooping Cough
(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) A. Lee Chisley, M. D.
2/15, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem
DATE OF BURIAL 2-16 1924
UNDERTAKER David Evans
ADDRESS 916 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF A-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83875

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3624 Ash ST. 13 WARD)

2-FULL NAME John H. Higdon

(a) RESIDENCE: No. 3624 Ash ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 82 yrs. 1 mos. 0 ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or, WIFE) Elizabeth E. Higdon

6 DATE OF BIRTH (month, day, and year) Jan 16th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Higdon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nancie Merritt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Elizabeth E Higdon
(Address) 3624 Ash St

15 Filed ... 19 ... Registrar

EB 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 1, 1924, to Feby 15, 1924, that I last saw him alive on Feby 14, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Second attack

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2/15 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	2/18/1924

20 UNDERTAKER Walter Davis, Funeral Director ADDRESS 3307 Paine St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83876

D 83876

CERTIFICATE OF DEATH.

4 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Municipal Tuberculosis Hospital ST., (WARD)

2-FULL NAME Louis Kaiser

(a) RESIDENCE NO. 152 E. Fayette st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Kaiser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline ??

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital records

(Address) M.T.H.

15 Filed FEB 16 1924 .19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1924, to Feb. 14, 1924, that I last saw him alive on Feb. 14, 1924, and that death occurred, on the date stated above, at 1.05 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally, M. D.

2-14-24, 19 (Address) Municipal Tec. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 16 1924 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Per. Wm. E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 83877 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 83877

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2567 Pennsylvania St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Unknown

(Residence in Baltimore: No. 2567 Pennsylvania St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	C.	—

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. About 45 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 067

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, .

11-BIRTHPLACE OF FATHER, (State or Country), .

12-MAIDEN NAME OF MOTHER, .

13-BIRTHPLACE OF MOTHER, (State or Country), .

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15. Filed ..... 192.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MAR 15 1924

MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 6, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Thos. Morrison M. D. (Coroner.)

Feb 15 1924 (Address) 3432 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
HOPKINS HOSPITAL	....., 19....
(20-UNDERTAKER, Bur. Health,	ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83878

CERTIFICATE OF DEATH.

91-002 D 83878

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 N Carey ST. 18 WARD)

2-FULL NAME Wm E Collier

(a) RESIDENCE NO. 208 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha L Collier

6 DATE OF BIRTH (month, day, and year): Dec 21, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Utility Man
(b) General nature of industry, business, or establishment in which employed (or employer): at Custom House
(c) Name of employer: 086

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frank Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ellicott City Md

12 MAIDEN NAME OF MOTHER: Davis Harden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ellicott City Md

14 Informant: Martha L Collier
(Address) 208 N Carey St

15 Filed FEB 16 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsies or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Chronic Heart.

(duration) yrs. 2 mos. ds.

(Signed) Geo L Radcliffe M. D.
(Coroner.)

, 192 (Address) 1625 K Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Lawn	Feb 18 192
20 UNDERTAKER	ADDRESS 1532
George J Smith	Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83879

D 83879

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 558 Robert ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary West

(a) RESIDENCE NO. 558 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of James West

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	99	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Moses Dell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Rosa Cuthbucks

(Address) 2118 Eutaw St

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

FEB 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1921, to Feb 15, 1924, that I last saw her alive on Feb 14, 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Renal Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

2/15, 1924 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Zion Cem — DATE OF BURIAL 2-18 1924

20 UNDERTAKER George T. A. Gibson — ADDRESS 1735 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83880

CERTIFICATE OF DEATH.

101-09 ✓ B 83880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 N. Kenwood Ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Earl Blagett

(a) RESIDENCE NO. 201 N. Kenwood Ave ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S

8a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 - 24

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Royal Blagett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanoverville Md

12 MAIDEN NAME OF MOTHER Goldie Lawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanoverville Md

14 Informant Royal Blagett (Address) 201 N. Kenwood Ave

15

B 1 6 1924

16 Robert E. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924, to Feb 13, 1924, that I last saw him alive on Feb 13, 1924 and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia, acute, primary (Lobar)

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lawson Wilkins, M. D.

2-13, 1924 (Address) 1014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Family Cemetery Parkville Md	2/16 1924

20 UNDERTAKER John C. Thorman

ADDRESS 3100 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83881

CERTIFICATE OF DEATH.

56

1-PLACE OF DEATH Hopkins

CITY OF BALTIMORE: (No. Johns Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Tucker

(a) RESIDENCE No 6571/2 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug 8/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Ernst Tucker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER May Boldes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Richmond Va.

14 Informant Ernst Tucker
(Address) 6571/2 W. Lexington

15 Filed FEB 16 1924 192 Robert E. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetany

Autopsy at Hopkins Hospital

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Active Ricketts

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. A. Collins, M. D.
(Coroner.)

Nov 16/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Patricks — DATE OF BURIAL 2/16 1924

20 UNDERTAKER John A Moran — ADDRESS 320 E Butler

CAUSE OF DEATH to be written in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83882

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. One Mosquman Court ST. 27 WARD)

2-FULL NAME Katherine Macsherry Brogden

(a) RESIDENCE NO. 1 Mosquman Court ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G Brogden

6 DATE OF BIRTH (month, day, and year) August 16 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard M. Macsherry

11 BIRTHPLACE OF FATHER (city or town) Martinsburg
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Emily Hillen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Richard Macsherry 2/16/24 3 Am
(Address) 210 Woodlawn Rd. Roland

B 16 1924 Robert P. Harrison, 19 .....
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15* 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/3, 1924, to 2/15, 1924, that I last saw h[illegible] alive on 2/15, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 15 yrs. mos. da.

CONTRIBUTORY (Secondary) Ulceration of mouth

Non tuberculous (duration) yrs. mos. 1Bx da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

2/15 1924 (Address) 1402 Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grew Cathedral Cem	Feb 18 1924
20 UNDERTAKER	ADDRESS
A. J. Perkins & Son Co	Oscar M. Mace Catonsville

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should file CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83883

D 83883

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen V. Fink

(a) RESIDENCE No. Mt Hope Retreat ST. 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) unk.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry S. Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lt Wheaton Pa

12 MAIDEN NAME OF MOTHER Rose H McSherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Records, Mt Hope Retreat

(Address) Mt Hope Balto Md.

EB 16 1924 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 23, 1923, to Feb 16th, 1924, that I last saw her alive on ~~Nov~~ Feb 16th, 1924, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

abt (duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Depression Psychosis

abt (duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Feb 16, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 2/18 1924

20 UNDERTAKER Henry C. Weems & Son

ADDRESS 805 N. Calvert St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83884

CERTIFICATE OF DEATH.

D 83884

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S- 4th St. N. WARD)

2-FULL NAME. Edward H. Thompson

(a) RESIDENCE NO. 621 S- 4th ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55!			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..."
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..."
(State or country)

14 Informant Police Dept.
(Address)

15 Filed FEB 16 1924 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. X ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Chester Blades, M. D.
Feb 16 1924 (Coroner.) (Address) 143 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City, N.Y.

DATE OF BURIAL 2/16 1924

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette Ave.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83885 ✓ D 83885

CERTIFICATE OF DEATH.

15 31

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 E Carey ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos Garnett Reed

(Residence in Baltimore: No. 1316 Carey St.; 72 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Aug. 18, 1851.
(Month) (Day) (Year)

7-AGE, 33 yrs. 5 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance work
(b) General nature of industry, business, or establishment in which employed (or employer): Ag

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Andrew Reed

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Annie Credith

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Reed

(Address) 1316 Carey St

15-

FEB 17 1924

Filed ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 14, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/13, 1924, to 2/14 1924, that I saw h— alive on 2/14 1924, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory Influenza

Sudden Pneumonia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) B. Merk Lentz, M. D.

2/15, 1924 (Address) 24 E. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Feb. 17, 1924

20-UNDERTAKER R. C. Ellis — ADDRESS 725 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83886 — 101-001 ✓ — D 83886

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Waters

(a) RESIDENCE No 810 Small ST ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. (est) mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Nov 3/23 inquiry

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	✓	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Mary Kuckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. R. A. Elliott
(Address): 1725 Ashland Ave

15 Filed FEB 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Probably Lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Waters (Coroner), M. D.

Feb 16/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Feb 17th 1924
20 UNDERTAKER: Mrs. R. A. Elliott	ADDRESS: 1725 Ashland Ave.

THE LAW requires that all the questions below shall be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83887

CERTIFICATE OF DEATH

90 D 83887

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N Broadway ST., 6 WARD)

2-FULL NAME Joseph Stern

(a) RESIDENCE NO. 312 N Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bailey Stern

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balt St

15 Filed FEB 17 1924 ROBERT. R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 1 yrs. mos. 14 ds.

(Signed) Frederick Lee Ruth, M. D.
(Coroner.)

Feb 16 1924 (Address) 1431 N Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	2/17 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83888

D 83888

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 E Fairmount St., 6 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Brown

(a) RESIDENCE No. 1920 E. Fairmount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Newspaper
(b) General nature of industry, business, or establishment in which employed (or employer) Sun Office
(c) Name of employer A. Sharretts

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Annie Brown
(Address) 1920 E Fairmount

15 Filed FEB 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intoxication

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Probably Myocarditis

(duration) 2 yrs. ....mos. ....ds.

(Signed) J. J. Walter, M. D.

(Coroner.)

Feb 16 1924 (Address) 508 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodedal — DATE OF BURIAL 2/17 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Milary Zukowski

D 83889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 83889

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Orleans ST., 6 WARD)

2-FULL NAME Milary Zukowski

(a) RESIDENCE NO. 1802 Orleans ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year): January 14-1854

7 AGE — Years: 70 — Months: 1 — Days: 1. — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): At his home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Anna Zukowska
(Address): 1802 Orleans

15 FEB 17 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1924

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1924, to February 14, 1924, that I last saw h.. alive on February 14, 1924, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria

(Signed) H. Zukowski, M. D.

16 2. 1924 (Address) 722 S. Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. — DATE OF BURIAL: Feb 15 19

20 UNDERTAKER: Jacob Finkowski — ADDRESS: 1528 S. Bond St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Boyer

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83890 D 83890

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. University Hospital St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Sellers Boyer

(Residence in Baltimore: No. 1013 Pleasant alley St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colo	Married

6-DATE OF BIRTH, Aug 23 1892
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
31 yrs. 5 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Boyer

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Ida Hayden

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Boyer

(Address) 1012 Pleasant alley

FEB 17 1924 ROBERT P. KRAUTER,
Filed ..... Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 13 192 4
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

.....(Duration) 2 Minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

.....(Duration) yrs. mos. ds.

(Signed) H. A. Kornblum M. D.
(Coroner.)

2 15 W. Mulberry St. 192 4 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Lebanon Cem	2/17 19 24
20-UNDERTAKER,	ADDRESS 1118
Samuel A Hensley	W Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83891

CERTIFICATE OF DEATH.

31 D 83891

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 934 S Paca St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elva P Joyce

(a) Residence No. 934 S Paca St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: ~~Female~~

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Franklin P Joyce

6-DATE OF BIRTH (month, day and year): Jan 22. 1874

7-AGE: 50 yrs. mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): France

PARENTS:

10-NAME OF FATHER: August Hemault

11-BIRTHPLACE OF FATHER (city or town) (State or Country): France

12-MAIDEN NAME OF MOTHER: Whitman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): France

14- (Informant): Franklin P Joyce

(Address): 934 S Paca

15- FEB 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 16, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 19 24 to Feb 16 19 24

that I last saw her alive on Feb 15 19 24

and that death occurred, on the date stated above, at 12,30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Nancy Boyd M D

, 19 (Address) 602 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 19 19 24

20-UNDERTAKER: W. E. Lichtner Sons — ADDRESS: 18th Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE (No. 4007 Brookline Ave St. 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Columbus Kirwan

(a) Residence No. 4007 Brookline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: George E. Kirwan

6-DATE OF BIRTH (month, day and year): Jany 1 1860

7-AGE: 64 yrs. 1 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Buyer
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing Factory
(c) Name of employer: Roberts & Co

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS:
10-NAME OF FATHER: Samuel Kirwan
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: Mary Hanson
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14 (Informant): George E. Kirwan
(Address): 4007 Brookline Ave

15- FEB 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 7 1924 to Feb. 14 1924

that I last saw him alive on Feb. 14 1924

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis

(Duration) several years yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) S. A. Bodde M. D

Feb. 16 1924 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feby 18 1924

20-UNDERTAKER: Wm J Tillman Son — ADDRESS: Norman

Should be carefully supplied. Ages should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00

D 83893

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2556 Hollins ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Hacker

(a) RESIDENCE. No. 2556 Hollins ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
f	w	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Hacker

6 DATE OF BIRTH (month, day, and year) June 19-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	57	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lenard Knuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Juliana Neu

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Appelhein (Sister)

(Address) 13 Aiken Hampden

Filed FEB 17 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16th 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 8th, 19..., to Feb 16, 1924

that I last saw h[illegible] alive on Feb 16, 1924

and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) - yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Labrippe

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bryan McCleary, M. D.

(Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 19 1924

20 UNDERTAKER Williams Cadwalader Baltimore ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Dalsheimer)

D 83894 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83894

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH Womens Hosp 14

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dalsheimer

(a) RESIDENCE NO. Marlborough apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 - 1924

7 AGE Years Months Days If LESS than 1 day, 24 hrs. or 50 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Hugo Dalsheimer

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Helen Mullen

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mr St Mullen
(Address) Marlborough Apts

15 Filed FEB 17 1924 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 17, 1924, that I last saw him alive on Feb 17, 1924, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C. Baldwin, M. D.

, 19 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew — DATE OF BURIAL: 2-17 1924

20 UNDERTAKER: David Sonkens — ADDRESS: Wilkens Ave

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

KODAK SAFETY FILM

Cor.—1-12-23—M&T—100 Bks.

D 83895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148 D 83895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S Edew ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Grosso

(a) RESIDENCE No. 204 S Edew. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Grosso

6 DATE OF BIRTH (month, day, and year) Sept. 11 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Rosso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Mongino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Grosso
(Address) 204 S. Edenson Ave

15 Filed FEB 7 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puer Convulsions

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1/2 ds.

(Signed) Geo Calvin Blake, M. D.
(Coroner.)

Feb 7 1924 (Address) 1424 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Holy Redeemer — DATE OF BURIAL Feb 19 1924

20 UNDERTAKER Kendall Heppe & Son — ADDRESS 37 N Howard

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12/D 83896

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3507 N. Charles St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Heald Price Peard

(a) Residence No. 3507 N. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank F. Peard

6-DATE OF BIRTH (month, day and year): Oct. 26. 1871

7-AGE: 52 yrs. 3 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home duties

(b) General nature of Industry, business, or establishment in which employed (or employer): (?)

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Richard W. Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Callie Heald

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14-

(Informant): Frank F. Peard

(Address): 3507 N. Charles St

FEB 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feby 16. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1923 to Feby. 16 1924

that I last saw h[er] alive on Feby 16 1924

and that death occurred, on the date stated above, at 5.23 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

myocardial Insufficiency

Chr. Nephritis 6 yrs. mos. ds.
(Duration)

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Dorsey M. D

19 (Address) 1129 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

20-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL: Feby 18 1924

20-UNDERTAKER: John. Ottschalk ADDRESS 1201 W. Fayette St

Should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83897

CERTIFICATE OF DEATH.

11-001 ✓ D 83897

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Bayard St ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Lyons

(Residence in Baltimore: No. 1129 Bayard St St.; ....yrs.,....mos.....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. May (Month) 31 (Day) 1869 (Year)

7-AGE.	If LESS than 1 day,
54 yrs. 5 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0440

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, James Lyons

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Kavanaugh

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mary Lyons

(Address)..... 1129 Bayard St

15-

FEB 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 15 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-14-1924, to 2-15-1924, that I saw him alive on 2-15-1924, and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration).....yrs.....mos. 2 ...ds.

(Signed) Geo. L. Hall M. D.

2-16..., 1924 (Address) Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Feb 18, 1924

20-UNDERTAKER	ADDRESS
John J. Feldmeier & Sons	Fulton & Lanvale St

Spec.—1-10-21—M&T—1500 Bks.

D 83898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 83898

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Bolton ST., 11 WARD)

2-FULL NAME Hattie Cooper

(a) RESIDENCE No. 1122 Bolton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard M. Cooper

6 DATE OF BIRTH (month, day, and year) Oct - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prospect Landing

(State or country) Eastern Shore Md

PARENTS

10 NAME OF FATHER Joseph Bowles

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Priscilla ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Josephine Simms

(Address) 1122 Bolton St

15 FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15 1924

17

I HEREBY CERTIFY, That I attended deceased from 2/2, 1924, to 2/15, 1924

that I last saw her alive on 2/5, 1924

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Evidence

(Signed) H. McCall, M. D.

2/16, 1924 (Address) 1129 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

20 UNDERTAKER C. J. Alexander

DATE OF BURIAL Feb 18 1924

ADDRESS 1426 Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83899

100-002

D 83899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Bolton St. 11 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Edwards

(Residence in Baltimore: No. 1118 Bolton St St.; yrs. (6 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Femal

4-COLOR OR RACE: Colored

5-Single, Married, Widowed or Divorced (Write the word.): Single

6-DATE OF BIRTH: June 16 (Month) (Day) 1918 (Year)

7-AGE: ..... yrs. 9 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: nr
(b) General nature of Industry, business, or establishment in which employed (or employer): nr

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Samuel Edwards

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Annie Barnes ~~Edwards~~ Jones

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Jones

(Address) 1116 Bolton St

FEB 18 1924 (Filed) 192.....

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 16 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap. Bronchites

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Pleurisy

(Duration) ..... mos. 2 ds.

(Signed) Geo Clinton Bladg M. D.

(Coroner) 2/17/24 192.... (Address) 1117 N Broad

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Pt Pelham Cem — DATE OF BURIAL: 2-18-1924

20-UNDERTAKER: Chas Eckels — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83900

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83900

118-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1338 Carroll St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Clark

(a) Residence No. 1338 Carroll St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Yrs. mos. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col'd.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1849

7-AGE, 75 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Dist Union

PARENTS.

10-NAME OF FATHER Dist Union

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Dist Union

12-MAIDEN NAME OF MOTHER Dist Union

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Dist Union

14-(Informant) Catherine Clark

(Address) 1338 Carroll St

15-Filed FEB 18 1924 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 17-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 16 1924 to Feb 16 1924

that I last saw her alive on Feb 16 1924,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Stone M. D

Feb 17 1924 (Address) 719 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	2-18 1924
20-UNDERTAKER.	ADDRESS
Paul Taylor	766 Penn

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1696H D 83901

CERTIFICATE OF DEATH.

100-00 D 83901

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 21 WARD)

2-FULL NAME William Squires

(a) RESIDENCE NO. 517 Archer St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 27, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X —	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Squires

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

FEB 18 1924 ROBERT R. KRAUTER, Registrar

FEB 18 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Feb 16, 1924, that I last saw him alive on Feb 14, 1924, and that death occurred, on the date stated above, at 6-20 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) "

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-Ray.

(Signed) Casper Iversoff, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marley Church Yard Laco ma — DATE OF BURIAL Feb 18, 1924

20 UNDERTAKER John F. Denning — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 83902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83902

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2605 Jefferson St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa D. Sitteg

(a) Residence No. 2605 Jefferson St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced~~ (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fredk W. Sitteg

6-DATE OF BIRTH (month, day and year) May 1–1865

7-AGE. 58 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Karl Kater

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dora Kaer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs. Chas. Schaefer

(Address) 2605 Jefferson St

15-

Filed ..... 192.. DUDLEY N. KRAUTER, Registrar.

FEB 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby 15–1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11– 1923 to Feb. 15– 1924

that I last saw h.. alive on Feb 15 – 1924

and that death occurred, on the date stated above, at 8 20 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dis – Valvular and Hypertrophy

(Duration) ....yrs. 4 mos. – ds.

CONTRIBUTORY (Secondary) General Anasarca –

(Duration) ....yrs. 1 mos. ....ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? –

What test confirmed diagnosis? Clinical

(Signed) Frank C Bramer M. D.

, 19 (Address) 125 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Matthews Cem — DATE OF BURIAL. Feby 18 1924

20-UNDERTAKER. John Ellis — ADDRESS 2098 Eden

Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hoey

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83903

90 D 83903

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp Gen/Hosp ST., 1 WARD)

2-FULL NAME George Hoey

(a) RESIDENCE NO. 512 S East Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Augusta L. Hoey

6 DATE OF BIRTH (month, day, and year) April 3 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57		11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hoey

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Crease

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Hospital Records

(Address)

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 16 19 24

17

I HEREBY CERTIFY, That I attended deceased from February 13, 19 24, to February 16, 19 24,

that I last saw h in alive on February 16, 19 24,

and that death occurred, on the date stated above, at 1 10/9 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.

.....(duration) 0 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

.....(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward Cameron, M. D.

, 19 (Address) Sinai Hospital Gen/Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Feb 19 1924
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	739 Eager

N. B. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Doroff.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83904

CERTIFICATE OF DEATH.

100 001

D 83904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218 E. Madison ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M. Doroff

(a) RESIDENCE NO. 2218 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	3	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Otto Doroff

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Edna Gladfelter

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Otto Doroff
(Address) 2218 E Madison

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16-1924

17

I HEREBY CERTIFY, That I attended deceased from 2-10, 1924 to 2-16, 1924

that I last saw h.e alive on 2-15, 1924

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) F. Fleming Duncan, M. D.

2-16 1924 (Address) 2001 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Feb 18 1924
20 UNDERTAKER Zinkler & Zinkler	ADDRESS 1734 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83905

CERTIFICATE OF DEATH.

100-001

D 83905

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Ward St ST., 21 WARD)

2-FULL NAME Thomas Appleby

(a) RESIDENCE NO. 1130 Ward St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 16 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER William Appleby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Jessie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr William Appleby

(Address) 1130 Ward St

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/10/24, 1924 to 2-16-, 1924

that I last saw him alive on 2-16-, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mortimer Adams, M. D.

, 19 (Address) 1117 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Feb 18 1924
20 UNDERTAKER Tom J Howard & Son Per J J Howard	ADDRESS Jerusalem

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 83906

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 83906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Womens Hospital

CITY OF BALTIMORE: (No. ..... ST. 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bowen

(a) RESIDENCE No. Jacksonville, Fla. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ? hrs or 32 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Neal E. Bowen

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Elizabeth McLaurin

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Florida

14 Informant Neal E. Bowen
(Address) Jacksonville Fla

15 Filed FEB 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1924 2:00 a.m. to Feb 15, 1924 10:25 a.m.

that I last saw him alive on Feb 15, 1924,

and that death occurred, on the date stated above, at 10 a. 9 m.

The CAUSE OF DEATH* was as follows:

Prematurity of birth.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. Arthur York, M. D.

, 19 (Address) Womens Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jacksonville Fla	Feb 18 1924

20 UNDERTAKER	ADDRESS
Josiah Dyker	1600 N North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83907

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 621st St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Letter

(a) Residence No. 703 E 21st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L. Letter

6-DATE OF BIRTH (month, day and year) Feb 10-1842

7-AGE. 81 yrs. 10 mos. 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Weller

11-BIRTHPLACE OF FATHER (city or town) Richardstown (State or Country), Md

12-MAIDEN NAME OF MOTHER, Susan P. Fiperides

13-BIRTHPLACE OF MOTHER (city or town) Londontown (State or Country), Md

14-(Informant) Mrs. E. Chaplain

(Address) 703 E. 21st St.

FEB 18 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 16-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1924, to Feb 16th, 1924, that I last saw h[illegible] alive on Feb 16th, 1924, and that death occurred, on the date stated above, at 7 00 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis Hypertension

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Angina & hypertension

(Signed) J. L. Clotard, M. D.

Feb 18th 1924 (Address) 40 N. Bisdle st

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Feb 18 1924

20-UNDERTAKER, Wetzenhoffer

ADDRESS 1737 W. Lafayette

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83908

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 529 N. Bond ST. 7 WARD)

2-FULL NAME William Phillips

(a) RESIDENCE NO. 529 N. Bond St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept 5 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 50

(b) General nature of industry, business, or establishment in which employed (or employer): House Painter

(c) Name of employer: L. H. Mellin

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF ~~MOTHER~~: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Florence Fahey

(Address) 529 N. Bond St.

15 FEB 18 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 12 1924 to Feb 17 1924

that I last saw him alive on Feb 17 1924

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary): La Grippe

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard Euslinger, M. D.

, 19 (Address) 15 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: 2/20 1924

20 UNDERTAKER: Phillip Henry

ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83909

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83909

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 45 Third Ave. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis Lightner

(a) Residence No. 45 Third Ave St., 25 Ward E. Brooklyn

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 20th 1921

7-AGE. 2 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), E. Brooklyn Balto Md.

PARENTS.

10-NAME OF FATHER, Martin J. Lightner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Catharine Herbert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Phila Pa.

14- (Informant) Martin J. Lightner.

(Address) 45 Third Ave E. Brooklyn

FEB 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 14th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 13th 24 to Feb 14 24

that I last saw him alive on Feb 14 24

and that death occurred, on the date stated above, at 8 25 P. m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) R. W. Johnson, M. D.

, 19 (Address) Brooklyn Bank Bldg

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Feb 18, 1924
20-UNDERTAKER, Lilly & Green	ADDRESS 403 S. Wolfe St

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83916

CERTIFICATE OF DEATH.

100-002

D 83916

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 250 S Ann ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Donahoo.

(a) RESIDENCE NO. 256 S. Ann ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Lawrence E. Donahoo

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Hartman

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Lawrence E. Donahoo
(Address) 256 S. Ann St

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lob - Bronchitis

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Ft Mucous Colitis

(duration) yrs. mos. ds.

(Signed) Geo Clinton Pfeiffer M. D.
(Coroner.)

Feb 18 1924 192 (Address) 1423 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb. 17 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 4038 Wolfe St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83911

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001 ✓

D 83911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. S.E. corner Hillen Rd & North Road St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen Marie Strahmeyer

(a) Residence No. S. Edgefield Rd & North ave St. 27 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of G. Oscar Strahmeyer

6-DATE OF BIRTH (month, day and year) May 30 1888

7-AGE. 35 yrs. 8 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Austria,
(State or Country),

PARENTS.

10-NAME OF FATHER, don't Know

11-BIRTHPLACE OF FATHER (city or town) don't Know
(State or Country),

12-MAIDEN NAME OF MOTHER, don't Know

13-BIRTHPLACE OF MOTHER (city or town) don't Know
(State or Country),

14- (Informant) G. Oscar Strahmeyer

(Address) North and Hollins Road

FEB 18 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 16 1924

17- I HEREBY CERTIFY, That I attended deceased from May 30, 1923, to Feb 15, 1924, that I last saw her alive on Feb 15, 1924, and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Examination

(Signed) [illegible] M. D.

2/18, 1924 (Address) 534 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge | DATE OF BURIAL, Feb 19 1924

20-UNDERTAKER. Geo. Weber & Son | ADDRESS 2503 Edmondson Ave

Should be carefully supplied. Note should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Eli J. Bennett.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83912

CERTIFICATE OF DEATH.

X 129 D 83912

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli F. Bennett

(a) RESIDENCE NO. Glyndon Balto Co Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19/1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll co Md

PARENTS

10 NAME OF FATHER Larkin S. Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll co Md

12 MAIDEN NAME OF MOTHER Catherine Bauman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll co Md

14 Informant Frank Gorsuch

(Address) Glyndon Balto co Md

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.17.24

17

I HEREBY CERTIFY, That I attended deceased from 1.30.24, 19..., to 2.17.24, 19...,

that I last saw h alive on 2.17.24, 19...,

and that death occurred, on the date stated above, at 12 00 A.M.

The CAUSE OF DEATH* was as follows:

Cellulitis of R leg. Edema.

Insania

7

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema. Ch Myocarditis

Arter. Sclerosis (duration) yrs. mos. 28 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clynical & Lab

(Signed) Jno A Somerkin, M. D.

. 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Pleasant Cemetery — DATE OF BURIAL: Feb 19 1924

20 UNDERTAKER Carroll co Md — ADDRESS: Reisterstown Md

J. F. Eline

N. B.—WHERE PHYSICIAN, NURSE OR OTHER ATTENDANT IS NOT AVAILABLE, INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 118 D 83913

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Maryland General Hospital ST., 14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Waters

(a) RESIDENCE No. Owings Mills Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 6 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X	1		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Owings Mills. Md.

PARENTS
10 NAME OF FATHER Emerset Waters
11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.
12 MAIDEN NAME OF MOTHER Lillian Amos
13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Emerset Waters
(Address) Owings Mills Md

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 16 1924

17 I HEREBY CERTIFY, That I attended deceased from February 16, 1924 to Febry 16, 1924.
that I last saw her alive on February 16, 1924
and that death occurred, on the date stated above, at 6.45 P m.
The CAUSE OF DEATH* was as follows:

Intestinal Intussusception

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Intestinal Stricture
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of Feb. 16-24
Was there an autopsy? Yes
What test confirmed diagnosis? Operation
(Signed) James Hulst Hutchinson M. D.
19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Feb 19 1924
20 UNDERTAKER: J. F. Eline — ADDRESS: Reisterstown Md

NOTE—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83914

CERTIFICATE OF DEATH.

14 D 83914

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1437 Argyle Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Giles

(a) RESIDENCE NO. 1437 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alma Giles

6 DATE OF BIRTH (month, day, and year) Jan 13 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Upholsterer
(b) General nature of industry, business, or establishment in which employed (or employer) 085
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Alma Giles
(Address) 1437 Argyle Ave.

FEB 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Feb. 16, 1924 (Address) 1502 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	2/18 1924
20 UNDERTAKER Samuel L. Hensley	ADDRESS W Biddle

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

D 83915

CERTIFICATE OF DEATH.

D 83915

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2637 Eastern Ave. ST., 76 WARD)

2-FULL NAME Wm. R. Hayes Hesse.

(a) RESIDENCE NO. 2637 Eastern Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed or divorced HUSBAND of (~~WIFE~~ of) Marie E. L. Hesse

6 DATE OF BIRTH (month, day, and year) May 25, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor do

(b) General nature of Industry, business, or establishment in which employed (or employer) K. of P. Castle

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Hesse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Bierley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Marie E. L. Hesse (wife)

(Address) 2637 Eastern Ave.

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1924.

17 I HEREBY CERTIFY, That I attended deceased from January 10, 1924 to February 16, 1924.

that I last saw him alive on February 13, 1924.

and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia. Primary.

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? ----- -----

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M Reinhardt, M. D.

2/16 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Feb 19 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 ✓ D 83916

1-PLACE OF DEATH

City of BALTIMORE: (No. 2223 Maryland Av St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Amélia Timanus

(a) Residence No. 2223 Maryland Av St., 17 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 2 mos. 7 ds How long in U. S., if of foreign birth? 85 yrs. 2 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Thomas Timanus

6-DATE OF BIRTH (month, day and year) Dec-23-1838

7-AGE, 85 yrs. 2 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) Baltimore. (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, David Carroll

11-BIRTHPLACE OF FATHER (city or town) Guilford (State or Country), Howard Co. Md.

12-MAIDEN NAME OF MOTHER, Ann Eliz. Ayler.

13-BIRTHPLACE OF MOTHER (city or town) Fenbreville (State or Country), Maryland

14- (Informant) Mr. D. L. Timanus (Son)

(Address) 2223 Maryland Ave.

15- Filed FEB 18 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb-17-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 7, 1924 to Feb 16, 1924 that I last saw h[illegible] alive on Feb 16, 1924 and that death occurred, on the date stated above, at 7.45 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Stanley McCleary, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, Feby-19, 1924

20-UNDERTAKER, [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. Avoid ambiguous terms. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 83917

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Sadler. (SADTLER)

(a) RESIDENCE NO. 321 E. 32d ST., 12 WARD Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., If of foreign birth? 68 yrs. 3 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	68	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Benj. Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Cordie Schumacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records at Sydenham Hospital (Address): Baltimore.

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to Feb 16, 1924, that I last saw her alive on Feb 16, 1924, and that death occurred, on the date stated above, at 4:50 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B MacGowan M. D.

2/16/24 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery — DATE OF BURIAL: Feb 18 1924

20 UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. [illegible] St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 83918

CERTIFICATE OF DEATH.

101-001 ✓

B 83918

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 176 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Pearl Weinstein

(a) RESIDENCE No. 4518 Eastern Ave ST., Johnny Cake Road WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fanny Weinstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Jankelovea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ben Weinstein

(Address) 4518 Eastern ave

15 FEB 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1924, to Feb 17, 1924, that I last saw her alive on Feb 17, 1924, and that death occurred, on the date stated above, at 4:36 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Unresolved Right Lobar pneumonia

(duration) yrs. 3/4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Howard M. Kerr, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 2/18 1924

20 UNDERTAKER Jack Lewis 1434 Walbrook

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83919

CERTIFICATE OF DEATH.

105 D 83919

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Dallas ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Bundy

(a) RESIDENCE NO. 112 N Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert Bundy

6 DATE OF BIRTH (month, day, and year) unknown 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Robert Bundy
(Address) 112 N Dallas St

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. mos. ds.

(Signed) J. H. Porter, M. D.
(Coroner.)

Feb 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb. 18 1924
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 125 Carlton

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83920 ✓ D 83920

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 E. Lexington ST., 5 WARD)

2-FULL NAME George McCoy

(a) RESIDENCE NO. 1130 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena McCoy

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 41; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Portsmouth

PARENTS

10 NAME OF FATHER: Tom McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Abbie Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Abbie Burns

(Address): 1130 E. Lexington

FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 15 1924 to Feb 16 1924

that I last saw him alive on Feb 16 1924

and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. & microscopic

(Signed) Robt F Greene M. D.

2-17-1924 (Address) 320 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: Feb. 19 24

20 UNDERTAKER: Chas. N. Johnson

ADDRESS: 1617 N. Arlington

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

83921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 83921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 W Hennetta ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pinkney

(a) RESIDENCE NO. 437 W Hennetta WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10-1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Roland Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Marie Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Mother (Marie Pinkney)

(Address) 431 W Hennetta St

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to Feb 16, 1924, that I last saw him alive on Feb 15, 1924 and that death occurred, on the date stated above, at 12.55 Am.,

The CAUSE OF DEATH* was as follows:

Examination due to congenital hypertrophic pylorus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Thomas Keese, M. D.

2-18-1924 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: Feb 18 1924

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83922

CERTIFICATE OF DEATH.

90 D 83922

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3623 Park Heights Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Wertheim.

(a) Residence No. 3623 Park Heights Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) March 4, 1848.

7-AGE. 75 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)

(State or Country) Germany.

PARENTS.

10-NAME OF FATHER Herz Wertheim.

11-BIRTHPLACE OF FATHER (city or town)

(State or Country) Germany.

12-MAIDEN NAME OF MOTHER Brina Katz.

13-BIRTHPLACE OF MOTHER (city or town)

(State or Country) Germany

11- (Informant) Mrs. Amelia Wertheim,

(Address) 3623 Park Heights Ave.

15- FEB 18 1924 ROBERT R. KEATER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2/16/24.

17- I HEREBY CERTIFY, That I attended deceased from Oct 17, 1923, to Feb. 16, 1924, that I last saw h.r alive on Feb. 15 1924 and that death occurred, on the date stated above, at 4 A.m.

The CAUSE OF DEATH* was as follows:

Heart disease (mitral regurg.)

2 to 3 months, probably, several years.

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical signs & symptoms

(Signed) J. L. Thennell M. D

2/16/1924 (Address) 2226 Madison Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Hebrew Cem.	2/18/....19..24.
20-UNDERTAKER, David Sondheim	ADDRESS 118-20 W. Mt. Royal Ave.

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 83923 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 83923

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 426 N. Bethel ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Johnson

(a) RESIDENCE No. 426 N. Bethel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27/1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Laura (Hughes) Johnson
(Address) 403 Lewis St. nr Orleans

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Specific Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphillis

(Reported Pres[illegible]Eye & Ear Hosp.) ds.

(Signed) J. S. Haines, M. D.
(Coroner.)

Feb 16/24 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL 2/18 192 21

20 UNDERTAKER Samuel H. Hemsley ADDRESS [illegible]

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 83924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83924

CERTIFICATE OF DEATH.

+117

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard Street ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Scoggins.

(a) RESIDENCE NO. Ellicott Howard Co. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Scoggins

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Edmond Ashley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Milly Savage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant University Hospital Records (Address)

Filed FEB 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb. 17. 1924.

that I last saw her alive on Feb 17 1924

and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Feb. 16, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) David R. Nevermen, M. D.

Feb 17 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co Guilford Baptist Cem.

DATE OF BURIAL Feb. 20 1924

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Hannah, 1823 N. Bal to St

D 83925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83925

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1323 James St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M Farrell

(a) Residence No. 1323 James St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary A Farrell

6-DATE OF BIRTH (month, day and year) June 21. 1871

7-AGE	If LESS than 1 day
52 yrs. 7 mos. 26 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Spec Police

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer General Electric

9-BIRTHPLACE (city or town) (State or Country), Harford County Md

PARENTS.

10-NAME OF FATHER Michael Farrell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Katherine Callahan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) Mary A Farrell

(Address) 1323 James St

15- Filed FEB 18 1924 ROBERT R. KRAUTER, Burial Permit Cl. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1922 to Feb 17 1924

that I last saw h. alive on Feb 17 1924

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-Ray

(Signed) Martin J Hahne M. D

, 19 (Address) 1822 N Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Harlem Grace Mtd

DATE OF BURIAL. 2/20 1924

20-UNDERTAKER Wm Cook

ADDRESS Sor E North Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Silvette 621 Washington Blvd

D 83926 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83926

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1925 North Patterson Park Ave. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Flora Long

(a) Residence No. 1925 N. Patterson Park Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 23. 1923

7-AGE. ....yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER John A Long.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Edna Goldhall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) John A. Long

(Address) 1925 N. Patterson Pk Ave

FEB 18 1924

ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 7 19 24 to Feb. 17 19 24

that I last saw h[illegible] alive on Feb 16 19 24

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid negative

(Signed) J M Driskill M. D

Feb 18 1924 (Address) 621 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Feb. 19 1924

20-UNDERTAKER. Wm. Cook — ADDRESS 502 E Fayette

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83927

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 525 S. Green St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Maggie Blackson

(Residence in Baltimore: No. 525 S. Green St. St.; yrs. Entire mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored Female

5-Single, Married, Widowed or Divorced. (Write the word.): Single

6-DATE OF BIRTH: June (Month) 1 (Day) 1906 (Year)

7-AGE: 18 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country). Dorsey Md

PARENTS.

10-NAME OF FATHER. Henry Blackson

11-BIRTHPLACE OF FATHER. (State or Country). Dorsey Md

12-MAIDEN NAME OF MOTHER. Mary Daly

13-BIRTHPLACE OF MOTHER. (State or Country). Sandtill Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Dallarry

(Address) 525 S. Green st

Filed FEB 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 15 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy~~ or Inquiry.) thereon and from the evidence obtained by said Inquest, au- ~~topsy~~ or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) W. H. Grason M. D.
(Coroner.)

2-18 1924 (Address) 1127 Saratoga

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Church Cemetery Sandtill Feb 19 1924

20-UNDERTAKER. ADDRESS
Wm Geo H Hooper 406 N. Carey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3413 Fairview Ave St., 15 Ward) 49

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence L. Marlin

(a) Residence No. 3413 Fairview Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Marlin

6-DATE OF BIRTH (month, day and year) Jan 25-1880

7-AGE. 43 yrs. mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ohio

PARENTS.

10-NAME OF FATHER. Anderson H. Marlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Julia Joseph

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa

14- Informant Agnes Marlin

(Address) 3413 Fairview Ave

15- Filed FEB 16 1924 19.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from July-1 19 22 to Feb-16 19 24

that I last saw h.. alive on Feb-16 19 24

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma of Right Thigh

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July-1922

Was there an autopsy? Yes

What test confirmed diagnosis? Pathologist

(Signed) Marlin A Shook M. D

Feb-17. 1924 (Address) 8062 Fullerton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Louisville Kentucky

DATE OF BURIAL, 2/18.., 1924

20-UNDERTAKER. Chas P. Ward & Son

ADDRESS 1111 North Royal Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use GREATEST CARE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S.A.E.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 713 E. Chase St., 10 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Shea

(a) Residence No. 713 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie Shea

6-DATE OF BIRTH (month, day and year): May 17-1845

7-AGE. 78 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS:

10-NAME OF FATHER: John Shea

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Mollie Shea

(Address): 713 E. Chase St.

15- FEB 18 1924 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 16-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924 to Feb 16, 1924, that I last saw h. alive on Feb 15, 1924, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Apoplexy. Arteriosclerosis

(The Nephritis was only Terminal)

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Hamilton M. D

2 18 24 (Address) 709 Chase St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem DATE OF BURIAL, 7/19 19 24

20-UNDERTAKER: Chas P. Maudlin ADDRESS 1818 North Royal Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS filling this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OAK

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83930 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83930

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1306 N. Caroline St., 9 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. O'Connor

(a) Residence No. 1306 N. Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of P. C. O'Connor

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 77 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS:

10-NAME OF FATHER, Jas Ryan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Margaret Lynch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mamie O'Connor

(Address) 1306 N. Caroline St

15- Filed FEB 16 1924, 192.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

Feb 17

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 16-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to Feb 16 1924

that I last saw h. alive on Feb 16 1924

and that death occurred, on the date stated above, at 3.40 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical

What test confirmed diagnosis?

(Signed) H. Thomas M. D.

(Address) 226 N Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 2/19 1924
Cathedral Cem	
20-UNDERTAKER	ADDRESS
Chas P. Kraus & Son	11 & W. Mt Royal ave

Altra

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83931

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 ✓ 83931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1023 Race ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hazel Dillihay

(a) RESIDENCE NO. 1023 Race ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	—	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Percy Dillihay

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Bertha Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Bertha Dillihay

(Address) 1023 Race St.

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

FEB 16 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/1924

17 I HEREBY CERTIFY, That I attended deceased from 2/14, 1924, to 2/16, 1924, that I last saw her alive on 2/16, 1924, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Teething Bron- Colitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gunby Bowley, M. D.

2/16, 19 (Address) 908 Shawan Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount auburn Cem — DATE OF BURIAL Feb 19 1924

20 UNDERTAKER John H Owens — ADDRESS 508 Lochst

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dec.—8-24-14—M. & T.—2000 Bks.

Aloysia M Bioply.

D 83932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83932

1-PLACE OF DEATH Sunday Sanitarium Asylum

CITY OF BALTIMORE: (No. Fremont Road ST., 28 WARD) REGISTERED No. C

2-FULL NAME Mrs. Aloysia M Bioply

Residence in Baltimore: No. Sunday Sanitarium Asylum Road

(If death occurred in a hospital or institution, give its NAME instead of street and number and add out No. 18.)

(Age 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 11 (Day), 1865 (Year)

7-AGE, 58 yrs. 9 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House
(b) General nature of industry, business, or establishment in which employed (or employer). Housework

9-BIRTHPLACE, (State or Country), Richmond Va

10-NAME OF FATHER, Bioply

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John D. Toomey

(Address) 1730 W. Lexington St.

Filed FEB 18 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 13 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1924, to Feb 18 1924, that I saw h alive on Feb 18 1924, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Arteriosclerosis

(Duration) yrs. mos.

(Signed) Alyson D. Commins M. D.

Feb 18, 1924 (Address) 1730 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 13 yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Richmond Va

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL, Richmond Va. DATE OF BURIAL, Feb 18, 1924

20-UNDERTAKER John Cottrell and Son ADDRESS Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

D 83933

HEALTH DEPARTMENT—CITY OF BALTIMORE

100_001 ✓

D 83933

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 E 33rd ST., 9 WARD)

2-FULL NAME William C. Watson

(a) RESIDENCE NO. 701 E 33rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Sarah R. Watson

6 DATE OF BIRTH (month, day, and year) Nov 4th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Willie Isaacs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant William J. Watson

(Address) 701 E 33rd St

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar ~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1924, to Feb 16, 1924, that I last saw him alive on Feb 16, 1924, and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Joseph T. Herring, M. D.

, 19 (Address) 1800 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Feby 20th 1924

20 UNDERTAKER George Schulling & Sons — ADDRESS 1126 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83934

HEALTH DEPARTMENT—CITY OF BALTIMORE

83934

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 E Fayette ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline D. Spiegel

(a) RESIDENCE No. 2316 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John F Spiegel

6 DATE OF BIRTH (month, day, and year) Sept 14th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md

PARENTS

10 NAME OF FATHER George Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Hilbing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John F Spiegel 2316 E Fayette St

15 Filed FEB 18 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to Feb. 25, 1924.

that I last saw h.. alive on Feb. 11, 1924

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L Benson M. D.

2.16.24 . 19 (Address) Owings Mills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jerusalem Lutheran Cemetery, Sorrento

DATE OF BURIAL: Feby 19 1924

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1126 E Monument St

N. B.—WRITE PLAINLY, WITH ONLARGE LETTERS. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83935

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-D 83935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Hanover St. ST.: 23rd WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Gough.

(a) RESIDENCE. No. 1623 Hanover St. ST., 23 WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March, 24, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2,	10,	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Douglas B. Gough.

11 BIRTHPLACE OF FATHER (city or town) Dont know. (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Clews.

13 BIRTHPLACE OF MOTHER (city or town) Alexandria, (State or country) Va.

14 Informant Douglas B. Gough, (Father). (Address) 1623 Hanover St.

15 Filed FEB 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 17, 1924, that I last saw him alive on Feb 17, 1924, and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell M. D.

Feb 17, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetary.	Feb. 19, 1924.

20 UNDERTAKER A. Howard Evans. ADDRESS 1438 S. Charles St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83936 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83936

16919 med

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Holly

(a) RESIDENCE NO. 604 Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 26 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Holly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amy Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 FEB 18 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 22 - 1924, to Feb 16 - 1924, that I last saw her alive on Feb 16, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (?)

Amyloidosis

Miliary Tbc. (?)

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. M. Jacobson, M. D.

2/17/1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters — DATE OF BURIAL Feb. 19, 24

20 UNDERTAKER Sam'l K. Chase Son — ADDRESS 1400 Pitcher

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83937 ✓ D 83937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83937

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 648 Cokesbury Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Clark

(a) RESIDENCE NO. 648 Cokesbury Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a ~~Married, widowed, or divorced~~ HUSBAND of ~~last WIFE of~~ Alice Clark

6 DATE OF BIRTH (month, day, and year) — 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Hart
(Address) 648 Cokesbury Ave

15 Filed FEB 18 1924, 19 Burial Permit Clerk
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to Feb 16, 1924,
that I last saw h. alive on Feb 16, 1924,
and that death occurred, on the date stated above, at 9.30 P m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred C Jewett, M. D.

Feb 18 1924 (Address) 24 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/19 1924

20 UNDERTAKER H. Talbert Hanes

ADDRESS 1315 Eutaw

CAUSE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AG

Spec—12-23-21—E.B.R.S.—400 Bks.

Emerica 800 Pattison Ph. Av.

D 83938

HEALTH DEPARTMENT—CITY OF BALTIMORE

106-005 D 83938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1749 Lamont St. St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert W. G. Chiveral

(a) Residence No. 1749 Lamont St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Sing'l

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 15 1923

7-AGE.	If LESS than 1 day.
....yrs. 2 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER Gilbert F. Chiveral

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary A Bradford

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Gilbert F. Chiveral

(Address) 1749 Lamont St.

15-

Filed FEB 18 1924 19 Robert P. Harris Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 16 19 24 to Feb 17 19 24

that I last saw h. living on Feb 16 19 24

and that death occurred, on the date stated above, at 2.0 P. M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? undetermined

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Sputum

(Signed) Fred Runcle M. D.

18-24 (Address) 500 N Gilmor

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	Feb 19, 1924

20-UNDERTAKER.	ADDRESS
Wm Cook	502 E North Ave

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 83939

HEALTH DEPARTMENT—CITY OF BALTIMORE

124 B 83939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Breit

(a) RESIDENCE NO. 1509 Linden Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilde Breit

6 DATE OF BIRTH (month, day, and year) March 15, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Hopkins Univ

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Gregory Breit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Tinkmoor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant University Hosp. Records

(Address) Corp Cond 9th Green Street

15 Robert F. Harrison, Registrar

B 1 81924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1924.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1924, to Feb. 17, 1924, that I last saw him alive on Feb. 17, 1924, and that death occurred, on the date stated above, at 4 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Feb. 12, 1924

Was there an autopsy?

What test confirmed diagnosis? Clinical & Autopsy Findings

(Signed) David R. Newcomer M. D.

Feb 11, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Feb. 19 1924
20 UNDERTAKER	ADDRESS
Williams Cook	502 E North

INFORMATION—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83940

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83940

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2725 Pinkney ST., 15 WARD)

2-FULL NAME Anna M. Mc Nulty

(a) RESIDENCE NO. 2725 Pinkney Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Mc. Nulty

6 DATE OF BIRTH (month, day, and year) July 24 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35 yr.	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 837
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER August Eigner

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Reisz

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Wm. H. Mc. Nulty
(Address) 2725 Pinkney Ave

15 Filed FEB 18 1924 192 Robert P. Harrison
Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

Feb 17, 1924 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feb 20 192 4

20 UNDERTAKER Fickler & Fickler — ADDRESS Eagan 739

CAUSE OF DEATH in plain terms, so that if it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83941

D 83941

CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2306 E. Biddle ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Paley

(a) RESIDENCE NO. 2306 E. Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Paley

6 DATE OF BIRTH (month, day, and year): Dec. 4, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	2	13	

8 OCCUPATION OF DECEASED: at home

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Joseph Holecek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Ellen Permane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Mary Mayfarth 2306 Biddle St

15 Filed ..... 19 Robert F. Harrison, Registrar

FEB 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17, 1924

17

I HEREBY CERTIFY, That I attended deceased from ..... 19.. , to ..... , 19.. ,

that I last saw h.. alive on ..... , 19.. ,

and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. B. Kelly, M. D.

Feb 19, 1924 (Address) 130 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 20 1924
20 UNDERTAKER	ADDRESS
Burke & Burke	1739 Eager

N. B.—WRITE PLAINLY, with indelible pencil or pen and ink. AGE should be stated EXACTLY. PHYSICIANS should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in giving information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83942

CERTIFICATE OF DEATH.

74 D 83942

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 W. North ave ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud M. Walter

(a) RESIDENCE. NO. 3032 W. North ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 - 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	4	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 004

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Clerk - Bakery

(c) Name of employer Government

9 BIRTHPLACE (city or town) (State or country) Boston

PARENTS

10 NAME OF FATHER George Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston.

12 MAIDEN NAME OF MOTHER Annie Birkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary A. Wise
(Address) 3032 W North ave

15 Filed FEB 18 1924 Robert P. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16th, 1924, to Feb 17, 1924, that I last saw h-er alive on Feb 16th, 1924, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Duff, M. D.

. 19 (Address) 1043 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 20 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83943

CERTIFICATE OF DEATH.

45 D 83943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Calhoun St., 19 Ward)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Martin

(a) RESIDENCE No. 224 N Calhoun St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Feb 13, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk in Store

(b) General nature of industry, business, or establishment in which employed (or employer) Dry

(c) Name of employer Mr Chas Martin

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Henry Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Hallet Monroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Nellie Martin

(Address) 224 N Calhoun St

15 FEB 18 1924 19 ..... Albert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Feb 18, 1924, that I last saw h alive on Feb 17, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Intestinal Tract.

From History 90 or 10 m.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

Feb 19 24 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Feb 20 1924
20 UNDERTAKER	ADDRESS 1532
George J Smith	Hollins

B—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED EXACTLY. PHYSICIAN should be careful in stating AGE. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH, so that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83944

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 83944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. East 33 Street ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Leroy Thomas

(a) RESIDENCE NO. 2140 Boyd Street ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 1. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.
(State or country)

PARENTS

10 NAME OF FATHER William A Thomas

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Miles

13 BIRTHPLACE OF MOTHER (city or town) ~~Maryland~~
(State or country)

14 Informant Carrie B Thomas
(Address) 2140 Boyd St

Filed FEB 16 1924. Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 19 24, to Feb. 16, 19 24, that I last saw him alive on Feb. 16, 19 24, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Right upper Lobar
Pneumonia, Left Bronchial

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jay Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL 1924

20 UNDERTAKER: F. B Pfeiffer — ADDRESS 2236 Eutaw Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. PHYSICIAN'S name and address should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83945

D 83945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 113 Wyoln Ave St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Elizabeth White

(a) Residence No. 113 Wyoln Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 1 1899

7-AGE. 25 yrs. 1 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, J. Hutson White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Grace Bierbower

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-(Informant) Mrs. J. Hutson White

(Address) 113 E. Wyoln Ave.

15-FEB 18 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 19 24 to Feb 17 19 24

that I last saw h.er alive on Feb 17 19 24

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isolde Dietrich M. D

2/18 1924 (Address) 2020 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Feb 19 1924
20-UNDERTAKER	ADDRESS
Wm. J. Richardson Sons	North Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83946

CERTIFICATE OF DEATH.

145 - 002

145 D 83946

1-PLACE OF DEATH CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. (ST.) 15 (WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Johnson

(Residence in Baltimore: No. 2129 Wallbrook Ave. 22 yrs., 3 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 28, 1901 (Month) (Day) (Year)

7-AGE, 22 yrs. 3 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Ross T. Hamlin

11-BIRTHPLACE OF FATHER (State or Country), Wash. D. C.

12-MAIDEN NAME OF MOTHER Lilly M. Pistel

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Johnson

(Address) 2129 Wallbrook Ave

15-

Filed FEB 18 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 18 (Day) 24 (Year), 191...

17- I HEREBY CERTIFY, That I attended deceased from 2-14-1924, to 2-18-1924, that I saw her alive on 2-18-1924, and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Embolism of Heart

moments (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Severe Instrument delivery. (Duration) ....yrs. ....mos. ....ds.

(Signed) S. Perot M. D.

2-18-, 1924 (Address) 2202 N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb. 20, 1924

20-UNDERTAKER Wm. J. Dickenson & Son — ADDRESS N. Pa

Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 83947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83947

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S. Dallas ST., WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Veronika Fobie Mach

(a) RESIDENCE No. 619 S. Dallas ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Mach

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 63.		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland. (State or country)

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Martin Mach. (Address) 619 S. Dallas St.

15 Filed FEB 18 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocarditis

Duration (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ..... M. D.

..... 192 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Feb 19—1924.
20 UNDERTAKER M. J. Sadowski.	ADDRESS 905 S Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83948 Municipal Hosp. CERTIFICATE OF DEATH. 90 D 83948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joe A Schmidt.

(a) RESIDENCE NO. 2211 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmidt

6 DATE OF BIRTH (month, day, and year) April 18, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar packer
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Pa.

PARENTS

10 NAME OF FATHER Joseph Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Weis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret A. Schmidt (Address) 2211 Federal St

15 Dated FEB 18 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Corpulmonale

(duration) 1 yrs. 1 mos. ds.

(Signed) G. Scott Wade, M. D. (Coroner.)

Feb 18/24 192 (Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb. 19 1924

20 UNDERTAKER William J. Schaeffer — ADDRESS 816 Mount

BEFORE SHOULD BE STRICTLY supplied. ACCURATE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83949

REGISTERED NO. D 83949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers Hospital of America ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta C. Baitzel

(a) RESIDENCE. NO. 1531 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Baitzel

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Geo. Baitzel
(Address) 1531 Orleans St

15 Filed . 19 Robert F. Harrison, Registrar

FEB 19 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 — 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16 . 1924 to Feb 18 . 1924

that I last saw h[e] alive on Feb 17 . 1924

and that death occurred, on the date stated above, at 12.30 A.m.

The CAUSE OF DEATH* was as follows: 1

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P. H. Johnson, M. D.

2/18 . 1924 (Address) 1210 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	2/21 1924
20 UNDERTAKER	ADDRESS
Chas. R. Mace Son	1181 W. Lafayette Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83950

CERTIFICATE OF DEATH.

90 D 83950

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 115 N. Lakewood Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Lyons

(a) Residence No. 115 N. Lakewood ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 57 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 862

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Michael Lyons

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Katherine Beere

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs John Murray

(Address) 115 N Lakewood Ave

15-

Filed..... Robert F. Harrison, Registrar.

B 1 81924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 16-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 5 - 1923 to Feb 16 1924 that I last saw him alive on Feb 15 1924 and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No Fry Exam

What test confirmed diagnosis? Clinical Signs Besides

(Signed) Jesse Clinton Beedes M. D

(Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Com | DATE OF BURIAL, 1924

20-UNDERTAKER, Chas F. Crane & Son | ADDRESS 1101 Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.K.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83951

CERTIFICATE OF DEATH.

101-001

D 83951

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 20 Ward)

Registered No.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Casper Shook

(a) Residence No. 433 Son Bventalow St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND ~~of (or) WIFE~~ of Mrs Mary Shook

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Casper Shook

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lancell Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs Mary Shook

(Address) 433 Son Bventalow

FEB 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 16-24

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 19 24 to Feb 16 19 24

that I last saw h alive on Feb 16 19 24

and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S Goldman M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOV BALTIMORE, CEM

DATE OF BURIAL, 2/19, 1924

20-UNDERTAKER, ROBERT BROOKS & SON

ADDRESS 608 CALHOUN HOLLINS ST

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83952

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Eutaw Place ST.: 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Bradshaw Thompson

(a) RESIDENCE. No. 1907 Eutaw Place ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick H. Thompson

6 DATE OF BIRTH (month, day, and year): Jan 9-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: J. W. Haden

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: — Bradshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Patrick H. Thompson 1907 Eutaw Place

15 FEB 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1924, to Feb 17th, 1924, that I last saw her alive on Feb 17th, 1924, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) L. B. Futterhouse, M. D.

(Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury N. C.	Feb 19 1924

20 UNDERTAKER: Chas. E. Franck ADDRESS: 807 Madison Ave.

All the items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1693 75 D 83953

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 83953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Louis Williams

(a) RESIDENCE NO. 518 (Usual place of abode) Dolphin St. WARD .....

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Williams

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	2	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None gd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Kunnard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL, Records (Address)

15 Filed FEB 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1924 to Feb 17, 1924

that I last saw h... alive on Feb 17, 1924

and that death occurred, on the date stated above, at 10.50 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis. Syphilitic Aortitis

Aortic Insufficiency. Aneurysm

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Hannon, M. D.

2/19, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Feb 20 1924
20 UNDERTAKER John H. Joaquim	ADDRESS 142 Ostend St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D 83954

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 Dover ST. N2 WARD)

2-FULL NAME Samuel Alexander Jones

(a) RESIDENCE NO. Island Creek Calvert Co. ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Jones

6 DATE OF BIRTH (month, day, and year) 11th. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER John W. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Selina Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant John W. Jones (Address) 637 Dover St.

15 Filed FEB 19 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17 1924

17

I HEREBY CERTIFY, That I attended deceased from 1/13, 1924, to 2/17, 1924,

that I last saw him alive on 2/17th, 1924,

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis cerebritis (duration) yrs. (subjective) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. Jackson, M. D.

, 19 (Address) 808 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooks. Calvert Co. Md.	Feb. 20 1924
20 UNDERTAKER John N. Goodman	ADDRESS 192 Lisbon St

N. B.—WHITE PAPER, WHITE INK AND NO RULING. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83955

CERTIFICATE OF DEATH.

74-001

74 D 83955

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 843 McKim St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brown

(a) Residence No. 843 McKim St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored	widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1855

7-AGE.	If LESS than 1 day,
69 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, Elijah Taylor

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14-

(Informant) Mary E Taylor

(Address) 843 McKim St

FEB 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 8, 1924, to Feb 16, 1924, that I last saw h alive on Jan 15, 1924, and that death occurred, on the date stated above, at 1.25 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J Edward Fisher M. D.

2-16, 1924 (Address) 1612 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pleasant Rest. Bel Co	Feb 19 1924
20-UNDERTAKER. John H Loader	ADDRESS 142 Uxbridge St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Meertens

D 83956 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 83956

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1909 Fleet St. St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Faukelina Meertens

(a) Residence No. 1909 Fleet St. St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female.

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry G Meertens

6-DATE OF BIRTH (month, day and year) Dec 3 1839.

7-AGE, 84 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Gd Vanderburg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Vd Kamm

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Henry G Meertens

(Address) 1909 Fleet St.

15- Filed FEB 19 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 17- 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 4- 19 24, to Feb 17- 19 24, that I last saw h.. alive on Feb 16- 19 24, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial - (Heart Block) Degeneration

Sudden - Death -

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Nephritis

(Duration) yrs. 1/2 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no -

What test confirmed diagnosis? usual

(Signed) Thos C Brincer, M. D.

, 19 (Address) 125 Dolphin -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon. DATE OF BURIAL, 2/26, 1924

20-UNDERTAKER, K. Heerman ADDRESS 32 S Broad.

copy

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83957

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N. Gilmore ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Hinton

(a) RESIDENCE NO. 518 N. Gilmore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47-8 yr.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Martin Hinton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Rufus Bond
(Address) 518 N. Gilmore St.

15 FEB 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Feb. 17, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence North Carolina

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-19 1924
20 UNDERTAKER	ADDRESS
Charles Alexander	826 Dundalk Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 83958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 Ward 001

D 83958

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 11 E. Chase ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. L. Clarke

(Residence in Baltimore: No. 11 E. Chase St. St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH. December (Month) 20 (Day), 1870 (Year)

7-AGE, 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frank P. Clark

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Mahew

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. C. Robinson

(Address) 11 E. Chase St

15-

FEB 19 1924 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Caused by Pneumonia

while peritoneal tuberculosis was present (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Feb 18 1924 (Address) 1659 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, Feb 20, 1924

20-UNDERTAKER Henry W. Jenkins & Son

ADDRESS Orchard & Fulton Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83959

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 801 S Port St. 1st Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rohde

(a) Residence No. 801 S Port St. 1st Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? 78 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Chas Rohde

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 78 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant) Mr Charles Rohde

(Address) 801 S Port St

15- Filed FEB 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 18-1924

17- I HEREBY CERTIFY, That I attended deceased from May, 1919, to Feb 18 1924, that I last saw h. alive on Feb 18 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Believed to Bronchopneumonia

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Senile Debility

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) P Brennan J Grennan, M. D.

Feb 18, 1924 (Address) 1900 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel | DATE OF BURIAL, Feb 20 19 24

20-UNDERTAKER, Peter Nicolaus | ADDRESS 2060 Eastern a

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-006 D 83960

1-PLACE OF DEATH

City of BALTIMORE: (No. 1459 Woodall St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Joseph Irwin

(a) Residence No. 1459 Woodall St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 15 1920.

7-AGE ✓ yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Clarence Jos. Irwin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Margaret Skumnik

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) C. J. Irwin

(Address) 1459 Woodall

15- Filed FEB 19 1924 Burial Permit Clerk

ROBERT P. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 18, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 16 '24 to Feb. 18 19 24

that I last saw ~~living~~ alive on Feb 17 19 24

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

2/18, 24 (Signed) Thos Fa Stevens, M. D

(Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Feb 20 19 24

20-UNDERTAKER. Chas. L Stevens ADDRESS 1501 E Lort

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001 D 83961

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 659 Light St. ST. 72 WARD)

2-FULL NAME George F. Gill.

(a) RESIDENCE NO 659 Light St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 7 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~WIFE of~~ HUSBAND of ~~DECEASED~~ Mollie Gill.

6 DATE OF BIRTH (month, day, and year) July 17, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	60	7	-----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 0 40
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Gill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rebecca Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mollie Gill (wife)
(Address) 3700 Calloway Ave.

15 Filed FEB 19 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas Asphyxia.
Accidental Death.
(Gas stove) (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) (duration) ..yrs, ..mos. ..ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner.)

Feb, 18, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Feb 19 1924
20 UNDERTAKER John Ortwein	ADDRESS 120 W Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83962

60-002

D 83962

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Winchester ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Laws

(Residence in Baltimore: No. 1301 Winchester St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 187? (Year)

7-AGE, 57 yrs. mos. da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Housework

9-BIRTHPLACE, (State or Country), Berryville Va

PARENTS.

10-NAME OF FATHER, Steve Strauge

11-BIRTHPLACE OF FATHER (State or Country), Berryville Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Berryville Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sadie Hall

(Address) 1301 Winchester St

15-

Filed FEB 1 1924, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 17, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924, to Feb 17 1924, that I saw h Er alive on Feb 17, 1924, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

.....

Toxic Goitre

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY..... Goitre
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. McCord M. D.

2/18, 1924 (Address) 2005 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Berryville Va — DATE OF BURIAL, 2/19, 1924

20-UNDERTAKER, Samuel H Housley — ADDRESS 778 W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83963

CERTIFICATE OF DEATH.

31 D 83963

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Mosher St ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Walston

(a) RESIDENCE No. 1628 Mosher ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Walston

6 DATE OF BIRTH (month, day, and year) June 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Town Laundry

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Reynold Redick

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Margaret Kimpler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Abraham Walston (Address) 1628 Mosher St

15 Filed FEB 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1923, to Feby 17th, 1924, that I last saw her alive on Feby 17th, 1924, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia with Endocarditis

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 456 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL South Hall MD

DATE OF BURIAL FEB 19 1924

20 UNDERTAKER Samuel T Beverley

ADDRESS 578 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U.S. A. K

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14001

D 83964

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 550 St. Mary St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Burgess

(a) Residence No. 550 St. Mary St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If ~~married, widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of David Burgess

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 55 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Brue

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, — Spriggs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Viola Burgess

(Address) 550 N. Mary St

15- Filed FEB 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 15-1924

17- I HEREBY CERTIFY, That I attended deceased from July 4 1924 to July 15 1924

that I last saw h.. alive on Feby 14 1924

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Frank E. Wagner M. D

2/15/ 1924 (Address) 116 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn cem	2-19-1924
20-UNDERTAKER, Daniel Easton	ADDRESS 916 E Lan

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Emily Johnson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83965

CERTIFICATE OF DEATH.

74-001

D 83965

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. E 1339 Hoard ST.: 71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Johnson

(a) RESIDENCE. NO. 1339 E Hoard ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	-		

8 OCCUPATION OF DECEASED Housework

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nellie Nash

(Address) 1336 Carroll St

15 Filed FEB 19 1924, 19.. ROBERT R. MAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1924, to Feb 18, 1924, that I last saw h[er] alive on Feb 17, 1924, and that death occurred, on the date stated above, at 10.05 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Long & Hoag, M. D.

19 (Address) 719 Bank Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-19-24
20 UNDERTAKER Wm. Easton	ADDRESS 716 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83966

CERTIFICATE OF DEATH.

90 D 83966

1-PLACE OF DEATH

City of BALTIMORE: (No. 830 N Saratoga St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Sarah Lewis

(a) Residence No. 830 Saratoga St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fem | 4-COLOR OR RACE, C | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 48 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Jacks

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) David Parker

(Address) 916 Pa ave

15- Filed FEB 19 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 16-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 19 24 to Feb 16 19 24

that I last saw h alive on Feb 16 19 24

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed J Moorwood M. D.

19 (Address) 939 W Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 2-19- 19 24
20-UNDERTAKER, Harry Taylor	ADDRESS 916 Pa ave

N. B.—NAME, RESIDENCE, AGE and CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83967

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 83967

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2636 Frederick Ave ST., 19th WARD)

2-FULL NAME Elizabeth M. Stivers

(a) RESIDENCE NO. 2636 Fred. Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. Left ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Feby 1/24

7 AGE: Years ..... Months ..... Days 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Stivers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Virginia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: John Stivers

(Address) 2636 Fred ave

Filed FEB 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 1, 1924 to Feby 17, 1924 that I last saw him alive on Feby 16, 1924, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Fred Koppenow M.D.

Feb 17 24 (Address) 1900 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Feb. 19 1924

20 UNDERTAKER: Geo. J. Schwab

ADDRESS 1401 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 83968

31 D 83968

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Warner — ST.: 21 WARD)

2-FULL NAME Frank. Lee

(a) RESIDENCE. No. 704 Warner ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Lee
(Address) 704 Warner St

15 Filed FEB 19 1924 ROBERT R. REAUBEN, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1923, to Feb 16, 1924, that I last saw h... alive on Feb - 13 - 1924, and that death occurred, on the date stated above, at 1 a — m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

Not Known — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Pathological & Physical

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. auburn ct	Feb. 19 1924
20 UNDERTAKER	ADDRESS
J. L. Brown and Son	158 W. Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 83969

JOHNS HOPKINS HOSPITAL.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Orlove

(a) RESIDENCE NO. 2909 Rockrose Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 20 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Orlove

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Orlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara Kalsoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Feb 19, 1924, that I last saw him alive on Feb 18, 1924, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 2/19 1924

20 UNDERTAKER Jack Levin — ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83970 ✓

D 83970

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So-Balto-Gen-Hosp-3 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Shemer

(a) RESIDENCE NO. S 1408 Eastern Av ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lft yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or cstablishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md-

PARENTS

10 NAME OF FATHER Simon Shymer

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Schwartz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland-

14 Informant Hospital Records
(Address)

15 FEB 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb-14, 1924, to Feb 18, 1924,

that I last saw her alive on Feb-18, 1924,

and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Herman Seidel, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Memorial Park

DATE OF BURIAL Feb 19 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83971

CERTIFICATE OF DEATH.

D 83971

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

Registered No. 118

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Frank Smith

(a) Residence No. 602 Saratoga Strut St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Charles Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-

(Informant).

(Address). JOHNS

15-

Filed FEB 19 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 9 1924 to Feb. 15 1924 that I last saw him alive on Feb. 15 1924 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Strangulated Inguinal Hernia - Gangrene of Bowel (Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 9, 24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Faulton M. D

. 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. HOPKINS HOSPITAL

DATE OF BURIAL. 19

20-UNDERTAKER. Commissioner Health.

ADDRESS

Per. WM. E. WOODALL

FEB 19 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK. The CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

57

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83972

CERTIFICATE OF DEATH.

17 46 D 83972

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 Pennsylvania Ave. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Warner

(a) Residence No. 1612 Pennsylvania Ave. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 6 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Warner

6-DATE OF BIRTH (month, day and year) June 30, 1858

7-AGE, 65 yrs. 7 mos. 18 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Arnst

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Scheidt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) John Warner

(Address) 1612 Penna Ave

FEB 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17 1924

17- I HEREBY CERTIFY, That I attended deceased from April, 1922 to Feb 17, 1924, that I last saw her alive on Feb 16, 1924 and that death occurred, on the date stated above, at 9.23 P. m. The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & appendages

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

2/18, 1924 (Address) 2020 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 20, 1924

20-UNDERTAKER, Josiah Syfer — ADDRESS Middle Neck Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83973

CERTIFICATE OF DEATH.

57

D 83973

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 238 S: East Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Eckhoff

(a) Residence No. 238 S: East Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Eckhoff

6-DATE OF BIRTH (month, day and year) 10-19-1856

7-AGE. 67 yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engeneer

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (city)..... (State or Country), Germany

14- (Informant) Louisa Eckhoff

(Address) 238 S: East Ave

15- Died FEB 19 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 18 Feb 24

17- I HEREBY CERTIFY, That I attended deceased from 1 July, 1923 to 18 Feb, 1924

that I last saw him alive on 18 Feb, 1924

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

To my knowledge 1 yrs 2 mos 18 ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sugar in urine

(Signed) D. F. Strohm M. D.

, 19 (Address) 301 S Eclwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Oak Lawn Cemetery	2/20/24 19....
20-UNDERTAKER. John Merrick	ADDRESS 2008 Allens

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS RECORD, EVERY ITEM OF WHICH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83974

CERTIFICATE OF DEATH.

83974

REGISTERED NO. 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cambridge Apartments 3406 St Paul ST. W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Merryman Lilling

(a) RESIDENCE NO. Cambridge Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Clare Lilling

6 DATE OF BIRTH (month, day, and year): July 19th 1839

7 AGE — Years: 82 — Months: 7 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business, or establishment in which employed (or employer): Bank

(c) Name of employer: Nat. Marine Bank

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Luther Lilling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland.

12 MAIDEN NAME OF MOTHER: Mary Clare Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland.

14 Informant: C. R. Lilling

(Address) 2237 Tusket Ave Evanston Ills.

15 FEB 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/17 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/16, 1924, to 2/17, 1924, that I last saw him alive on 2/17, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. B. Lehart M. D.

2/19 1924 (Address) 1400 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Feb 20 1924

20 UNDERTAKER: Henry H Kruken Sons Co — ADDRESS: McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

(Rossa)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83975

CERTIFICATE OF DEATH.

38

D 83975

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Rossa

(a) Residence No. 1011 Summerset St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Barbara M. Rossa

6-DATE OF BIRTH (month, day and year) Feb. 24 1873

7-AGE. 50 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Joseph Rossa

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Francis Russ

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Baltimore Md.

14-

(Informant) Municipal Hospital Records

(Address).....

15-

FEB 19 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-19-24

17- I HEREBY CERTIFY, That I attended deceased from 2-14, 1924, to 2-19, 1924 that I last saw him alive on 2-18, 1924 and that death occurred, on the date stated above, at 4:00 p.m.

The CAUSE OF DEATH* was as follows:

Syphilis

C. N. S. Syphilis

Tabes Dorsalis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Drane M. D

2-19-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	February 22, 1924
20-UNDERTAKER.	ADDRESS
Henry Hoeck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every number should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓
D 83976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 952 N. Eden ST., 10 WARD)

2-FULL NAME Mary Ann. Hallamyer

(a) RESIDENCE NO. 952 N. Eden ST., 10 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. — mos. — ds. How long in U. S., if of foreign birth? 79 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank C. Hallamyer

6 DATE OF BIRTH (month, day, and year) June 9 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Hollmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Leo. F. Hallamyer
(Address) 952 N. Eden St

15 FEB 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16. 1924 to Feb. 25 1924, that I last saw h[illegible] alive on Feb. 29. 1924, and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Senile Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 101 Chesapeake St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Feb. 20 1924

20 UNDERTAKER Henry Hook (Sons) — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Eugene Hudson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83977

CERTIFICATE OF DEATH.

101-001 ✓ D 83977

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 W Lee St. 22 WARD)

2-FULL NAME Eugene Hudson

(a) RESIDENCE. No. 511 W Lee St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col Mate

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 10/1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4 Months	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER George Hudson

11 BIRTHPLACE OF FATHER (city or town) Boston Mass
(State or country)

12 MAIDEN NAME OF MOTHER Clara Christian Hudson

13 BIRTHPLACE OF MOTHER (city or town) Northampton Va
(State or country)

14 Informant Clara Christian
(Address) 511 Lee St

15 Filed , 19

Registrar

FEB 19 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1924, to Feb 17, 1924, that I last saw him alive on Feb 16, 1924, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Do Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. B. Fowler, M. D.

(Address) 712 S Bond St Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Feb 19 1924
20 UNDERTAKER	ADDRESS
Jno Scott Hodges	406 W Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

George F. Narer

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 83978

CERTIFICATE OF DEATH. 37

D 83978

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Annapolis Ave St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo F. Narer

(Residence in Baltimore: No. 1215 Annapolis Ave St.; 62 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 12 (Month) 22 (Day), 1858 (Year)

7-AGE, 65 yrs. 2 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Christian Narer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbary Myer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Narer

(Address) 1215 E. Annapolis Ave

15-

FEB 19 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 1 1923, to Feby 15 1924, that I saw h[illegible] alive on Feby 16 1924, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ....yrs....mos....ds.

(Signed) H. B. Hall M. D.

2-16-, 1924 (Address) Walbrook Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Feb 20, 1924

20-UNDERTAKER Jos Joerdens & Son — ADDRESS 2178 S. Bway

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83979

CERTIFICATE OF DEATH.

38 D 83979

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Ambrose Flaherty

(a) Residence No. 326 N. Fremont St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1861

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cook

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore, Md

(State or Country).

PARENTS.

10-NAME OF FATHER. John Flaherty

11-BIRTHPLACE OF FATHER (city or town). Baltimore, Md

(State or Country).

12-MAIDEN NAME OF MOTHER. Ellen Dellaway

13-BIRTHPLACE OF MOTHER (city or town). Penn

(State or Country).

14- (Informant) Municipal Hospital Records

(Address).....

FEB 19 1924

Robert P. Harrison, 192.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-18-24

17- I HEREBY CERTIFY, That I attended deceased from 12-28 1923 to 2-18 1924

that I last saw h[illegible] alive on 2-18 1924

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis

Cirrhosis of Liver

(Duration) yrs. 9 mos. (history) ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Bruce M. D

2-16. 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Peters Catholic	Feb. 21st 1924
20-UNDERTAKER.	ADDRESS
Wilson W. Sherwin	118 Edmondson Ave

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 83980

100-001 ✓

B 83980

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3816 Fernwood Ave ST., 26 WARD)

2-FULL NAME Marian A. Lauer

(a) RESIDENCE NO. 3816 Fernwood Ave ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Lauer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel Flynn

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant William Lauer
(Address) 3816 Fernwood Ave.

15 EB 19 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 1st, 1924, to Feby 18th, 1924, that I last saw her alive on Feby 15th, 1924, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, primary

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dilated Heart.

(duration) - yrs. - mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Wm. L. Forsyth, M. D.

, 19 (Address) 928 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Feb. 20 1924
20 UNDERTAKER Lilly & Yates.	ADDRESS 403 S. Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83981

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 83981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Arundel Corporation Ship Yard.

REGISTERED NO.

CITY OF BALTIMORE: (No. Fairfield. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Lockhart.

(a) RESIDENCE No 311 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 7, 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Operator on dredge.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Arundel Corporation.

9 BIRTHPLACE (city or town) (State or country) Falmouth, Me.

PARENTS

10 NAME OF FATHER Sanders Lockhart.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia.

12 MAIDEN NAME OF MOTHER Emma Lunt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine.

14 Informant Amanda Foster.
(Address) 311 N. Broadway.

15 Filed FEB 19 1924, 192
Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February, 16, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Feb. 18, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass Pg Cem R.R.

DATE OF BURIAL Feb 19 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83982 ✓ X129 D 83982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospital. 4

CITY OF BALTIMORE: (No. Lombard & Green ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M W Lite

(a) RESIDENCE NO. Pasadena Md. ST., WARD Pasadena Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Black Smith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas M White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Baltimore City Hospital Lombard & Green Sts

15 Filed FEB 19 1924, 19.... Robert P. Harrigan, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924, to Feb 17, 1924, that I last saw him alive on Feb 17, 1924, and that death occurred, on the date stated above, at 8:30 P.m.

The CAUSE OF DEATH* was as follows:

Sub Acute Nephritis. Uraemia

(duration) yrs. mos. days

CONTRIBUTORY (Secondary) Hypertension of Circulation of Blood. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory Tests for Urine and Spinal Fluid Autopsy

(Signed) W Wallace Walker M. D.

, 19 (Address) Lombard & Green Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL Feb 20 1924

20 UNDERTAKER John H Denny ADDRESS 715 Light St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 11 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Pochhast

(a) Residence No. 117 W. Lanvale St., W. Lanvale Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 8 1902

7-AGE. 21 yrs. 10 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS:

10-NAME OF FATHER, Wm Pochast

11-BIRTHPLACE OF FATHER (City or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Anna

13-BIRTHPLACE OF MOTHER (City or town) (State or Country). Germany

14- (Informant) Wm Pochast

(Address) 117 W. Lanvale

15- Filed FEB 19 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Febr. 10 1924 to Feb 16 1924

that I last saw h[illegible] alive on Feb 16 1924,

and that death occurred, on the date stated above, at 10.10 m

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood count Widal

(Signed) M. Alexander Worley M. D

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem 2/20 19 24

20-UNDERTAKER Forge & Turley ADDRESS Fulton & Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83984

CERTIFICATE OF DEATH.

D 83984

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2439 McCulloh ST., 13 WARD)

2-FULL NAME James F Brown

(a) RESIDENCE. No. 2439 McCulloh ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced (write the word)~~
Male	Blk	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 7 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Alex Brown

11 BIRTHPLACE OF FATHER (city or town) Easton (State or country) Ga

12 MAIDEN NAME OF MOTHER Ethel Williams

13 BIRTHPLACE OF MOTHER (city or town) Easton (State or country) Ga

14 Informant Alexander Brown
(Address) 2439 McCulloch

15 Filed FEB 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1924, to Feb 18th, 1924, that I last saw him alive on Feb 17th, 1924, and that death occurred, on the date stated above, at 7. P M.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas C Carson, M. D.

19 (Address) 1063 Myrtle ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	2.20- 1924
20 UNDERTAKER Jos Henry Smith	ADDRESS 758 Dolphin

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83985

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1369 N. Calhoun

CITY OF BALTIMORE: NO. Balto md ST.: 15 WARD) 1½ yrs

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ozwell Smith

(a) RESIDENCE. NO. 1369 Calhoun ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1922

7 AGE 1 Years 5 Months Days / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) (none)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Bernard Smith

11 BIRTHPLACE OF FATHER (city or town) St mary's Co md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Price

13 BIRTHPLACE OF MOTHER (city or town) St mary's Co md
(State or country)

14 Informant Mary Smith
(Address) 1369 Calhoun St

15 FEB 20 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-194

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 16, 1924, that I last saw h. alive on Feb 16, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1369 Calhoun St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W R Boyton, M. D.

. 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL Feb. 20 1924

20 UNDERTAKER Joseph a Farrell

ADDRESS 2319 Division St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 83986

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 83986

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1144 N Stricker ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME June Shotswood

(Residence in Baltimore: No. 1144 N Stricker St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec 5th, 1923
(Month) (Day) (Year)

7-AGE. ..... yrs. 2 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE. (State or Country), City

PARENTS.

10-NAME OF FATHER. J. G. Shotswood

11-BIRTHPLACE OF FATHER (State or Country). Philadelphia

12-MAIDEN NAME OF MOTHER Helen Friedman

13-BIRTHPLACE OF MOTHER (State or Country). New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. G. Shotswood

(Address) 1144 N Stricker St

15-

FEB 20 1924 191 ROBERT R. KRAUTER,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 19, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy (Coroner.) M. D.

Feb 19 1924 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Feb 21, 1924

20-UNDERTAKER Spence & Wright

ADDRESS 1644 Mary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83987

CERTIFICATE OF DEATH.

10 W

D 83987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2624 Guilford Ave ST.: W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fritz Schleunes

(a) RESIDENCE. NO. 2624 Guilford Ave ST., 12 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? 42 yrs. 0 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel H. Schleunes

6 DATE OF BIRTH (month, day, and year) Jan-29-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paying Teller

(b) General nature of Industry, business, or establishment in which employed (or employer) Banking

(c) Name of employer Citizens Savings Bank

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Schleunes

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilde Schleunes

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Penna.

14 Informant Mrs Mabel H Schleunes (wife)

(Address) 2624 Guilford Ave

FEB 20 1924 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 31 1924, to Feb 17 1924.

that I last saw him alive on Feb 17 1924.

and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

acute Bronchitis followed by Pleurisy on Feb. 15th 24

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo W Hemmeter M. D.

Feb 19, 1924 (Address) 2002 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 20 1924

20 UNDERTAKER

T & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT mation should be carefully supplied. AGE should be stated EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83988

CERTIFICATE OF DEATH.

31 D 83988

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 E. Madison ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony C. Mesenhalter

(a) RESIDENCE NO. 2000 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11 1886

7 AGE: 38 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Compositer

(b) General nature of industry, business, or establishment in which employed (or employer): 06

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Simon Mesenhalter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Pauline Mattes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Mr. Simon Mesenhalter

(Address) 2000 E Madison

15 FEB 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1924

17

I HEREBY CERTIFY, That I attended deceased from January, 1923, to February 18, 1924, that I last saw him alive on February 18, 1924, and that death occurred, on the date stated above, at 1 A.M m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) ... yrs. 5 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Feb 19. 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 22 1924

20 UNDERTAKER: Jos J Stutson 1561 N.

ADDRESS: Hazelwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 83989 HEALTH DEPARTMENT—CITY OF BALTIMORE D 83989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Monument & Rutland St

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie Goldstein

(a) RESIDENCE NO. 205 N. Front St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	M	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Goldstein

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Dinkan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dinkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

FEB 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1923, to Feb 19, 1924, that I last saw h alive on Feb 19, 1924, and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Diabetes + Hemiplegia 2 mos,

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & lab.

(Signed) Isidor L. Levy, M. D.

Feb. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery

DATE OF BURIAL 2/20 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 83990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83990

CERTIFICATE OF DEATH.

Registered No. 91-09

1-PLACE OF DEATH

City of BALTIMORE: (No. 3119 Abell Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Blight Roberts

(a) Residence No. 3119 Abell Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~: Caroline A. Roberts

6-DATE OF BIRTH (month, day and year): April 26, 1863

7-AGE: 58 yrs. 9 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Coal Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Coal Co

(c) Name of employer: Self

9-BIRTHPLACE (city or town) (State or Country): Ga

PARENTS

10-NAME OF FATHER: Thomas Albert Roberts

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ga

12-MAIDEN NAME OF MOTHER: Rebecca Josephine Mooney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ga

14-(Informant) Caroline A. Roberts

(Address) 3119 Abell ave

15-

Filed FEB 20 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 18, 1924

17-I HEREBY CERTIFY, That I attended deceased from Aug — 21, to Feb 18 1924

that I last saw him alive on Feb 18 1924

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Ascending Arch of Aorta

(Duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Rupture of Aneurism

(Duration) yrs. 15 mos. Min.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr. Reichard

(Signed) H. L. Reichard M. D

(Address) 3708 Auchentoroly Ter

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Warren Pa — DATE OF BURIAL: Feb. 20, 1924

20-UNDERTAKER: John O. Mitchell — ADDRESS: 130 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 83991

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83991

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2839 Boarman Ave St. 15 WARD)

2-FULL NAME Margaret Louise Levy

(a) RESIDENCE NO. 2839 Boarman Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Leonard G. Levy

6 DATE OF BIRTH (month, day, and year) Jan 22 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Duties
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Elliott

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Elliott

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant James H Levy
(Address) 2839 Boarman Ave

15 FEB 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1924, to Feb 19, 1924, that I last saw her alive on Feb 17, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? None

What test confirmed diagnosis? None

(Signed) Frank C. Wilson, M. D.

2-20 1924 (Address) 2636 Kate Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb 21 1924
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83992

CERTIFICATE OF DEATH.

D 83992

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Gold St St.: ..... WARD)

2-FULL NAME Julia Wallace

(a) RESIDENCE. NO. 701 Gold St ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Wilbert Wallace

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Wallace

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wilbert Wallace (Address) 701 Gold St

15 [illegible] 19 ..... ROBERT R. KRAUTER Burial Permit Clerk.

FEB 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 - 19 24

17

I HEREBY CERTIFY, That I attended deceased from Feb 12, 1924, to Feb 17, 1924, that I last saw h[illegible] alive on Feb 17, 1924, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Marcellus E. Gray, M. D.

, 19 (Address) 1445 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lion — DATE OF BURIAL: Feb 20 1924

20 UNDERTAKER: Jos A. Farrell — ADDRESS: 2319 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83993

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 North Mount St. ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Bevans

(a) RESIDENCE. No. 324 N. Mount St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Bevans

6 DATE OF BIRTH (month, day, and year) May 15, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Northumbland Co. Va.

PARENTS

10 NAME OF FATHER Louis Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northumbland Co. Va.

12 MAIDEN NAME OF MOTHER Margurette Church

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northumbland Co. Va.

14 Informant Charles Bevans
(Address) 324 N. Mount St

15 Filed FEB 20 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 16th. 1924, to Feb. 18th. 1924, that I last saw her alive on Feb. 18th. 1924, and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Acct. Parenchymatous Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Walter J. Hickson, M. D.

. 19 (Address) 1618 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Feb. 20 1924

20 UNDERTAKER Wm. H. C. Elliott ADDRESS 172 Eastland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 83994 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

100-001 D 83994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 729 S. Potomac St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Diggs

(a) Residence No. 729 S. Potomac St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 24-1867

7-AGE. 56 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Retired Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 086
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Daniel Diggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Ema V. Diggs
(Address) 729 S. Potomac St.

15. FEB 20 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 17-1924

I HEREBY CERTIFY, That I attended deceased from Feb-9, 1923, to Feb-17, 1923, that I last saw h.. alive on Feb-17, 19.., and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..yrs. ..mos. 4 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(Duration) ?yrs. ..mos. ..ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Nathan J. Woodard M. D

, 19 (Address) 308 S. O'Donnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem. DATE OF BURIAL, Feb 21, 1924

20-UNDERTAKER. Stephen L. Fialkowski ADDRESS 1000 Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 83995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 83995

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Little

(a) RESIDENCE No 322 Diamond St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Georgia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant St. Joseph Hospital
(Address)

Filed FEB 20 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

51

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/24[92]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia
Chronic Endocarditis-Mitral
Insufficiency
(Entered Hospital Feb 6/24)
(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Syphillis
(Duration) yrs. mos. ds.

(Signed) [signature], M. D.
(Coroner.)

Feb 19/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs., ...mos., ...ds. In the State.....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health. — ADDRESS

Per Wm. R. WOODALL

THE MORGUE FEB 20 1924

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, PLACE OF DEATH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83996

CERTIFICATE OF DEATH.

11-001

D 83996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N. Bruce ST., 19 WARD)

2-FULL NAME Thomas Arthur Johnson

(a) RESIDENCE NO. 530 N. Bruce ST., 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		37	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Archer Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nettie Tayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 FEB 2 0 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. Feb. 18, 1924.

that I last saw him alive on Jan Feb. 18, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James M. Hayer, M. D.

2/19. 1924 (Address) 613 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

FEB 20 19

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

57

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 83997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 161-002

D 83997

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 N. Dallas ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mahone

(a) RESIDENCE. NO. 10 N. Dallas ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Samuel Mahone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Indies

12 MAIDEN NAME OF MOTHER Sadie Smith

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Sadie Mahone
(Address) 10 N Dallas

15 FEB 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1924, to Feb 18, 1924, that I last saw h... alive on Feb 18, 1924, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

(a) Atelectasis
Bilateral

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Accident protracted

Labor (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wilbur Burns, M. D.

2-19-24 19 (Address) 2017 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ... 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

FEB 20 1924

WM. R. WOOBALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83998

CERTIFICATE OF DEATH.

160 D 83998

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 N. Mount ST., 16 WARD)

2-FULL NAME Infant Chase

(a) RESIDENCE NO. 828 N. Mount ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 3 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male — 4 COLOR OR RACE: Colored — 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Feb. 15-24

7 AGE — Years: ✓ — Months: — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co Md.

12 MAIDEN NAME OF MOTHER: Bettie Lindsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Wm Chase
(Address): 828 N. Mount St

15 FEB 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1924, to Feb. 18, 1924, that I last saw him alive on Feb. 18, 1924, and that death occurred, on the date stated above, at 11:45 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): Undernourished

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

2/20 1924 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. — DATE OF BURIAL: 2/20 1924

20 UNDERTAKER: Edward C Hawley — ADDRESS: Rosedale

KAPS • ARCHIVAL • BOOK

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83999

CERTIFICATE OF DEATH.

161-001 D 83999

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maly. Draneby Vy Hospl. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Boy Paymer

(Residence in Baltimore: No. 100 N. Gilmore St. St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, 1 30, 1924. (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Barney Paymer

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Pearl Klein

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barney Paymer

(Address) 100 N. Gilmore St

FEB 20 1924, 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 20, 1924. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1924, to Feb 20 1924, that I saw h.. alive on Feb 20 1924 and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia G. M. D.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Lyman V. Abbatt M. D.

Feb 20, 1924 (Address) 1032 N. Caroline St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Chem Shalom Cem — DATE OF BURIAL, Feb 20, 1924

20-UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 E 23rd St., 12 Ward)

2-FULL NAME Woodford Johnson

(a) RESIDENCE No. 321 E 23rd St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

1924 D 84000

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Louis Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Hebron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Thos. J. Willis Coroner
(Address) 321 E 23rd St

15 Filed FEB 20 1924, 19 ROBERT R. KRAUDER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 18, 1924, that I last saw him alive on Feb 16, 1924, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Heart failure
(Uncomplicated to Limit)

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Age and Hardwork

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) D. Wall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 20 1924

20 UNDERTAKER Roger T. A. Gibson

ADDRESS 1737 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84001

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S Potomac ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Penna

2-FULL NAME Sarah E. Wirt

(a) RESIDENCE NO. 506 S Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Joseph Hurst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Priscilla Zahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Mrs. Campbell (Address) 506 S. Potomac St

15 Filed ..... 19 ..... REGISTRAR, Burial Permit Clerk

FEB 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 14, 1924, to Feb 18th, 1924, that I last saw her alive on Feb 18th, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

Personal Knowledge

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Fod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kenneth Square Penna	2/20 1924
20 UNDERTAKER	ADDRESS
John A Moran	3000 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Sterling

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84002

38 D 84002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 776 Bradley Av ST., 17 WARD)

2-FULL NAME George Sterling

(a) RESIDENCE No. 776 Bradley Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) about 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer unknown

9 BIRTHPLACE (city or town) ...
(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Maryland

14 Informant Cecil Sterling
(Address) 331 E. Lanvale St

15 Filed FEB 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Hennessy, M. D.
(Coroner.)

Feb 19, 1924 (Address) 1 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2-21-1924

20 UNDERTAKER David Easton

ADDRESS Pa Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 84003 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 84003

CERTIFICATE OF DEATH. X146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Park Ave. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Stewart

(a) RESIDENCE NO. 1105 Park Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? Virginia yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colrd	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm T. Stewart,

6 DATE OF BIRTH (month, day, and year) About 1892 query

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Wm. T. Stewart
(Address) 1105 Park Ave.

15 FEB 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) miscarriage

(duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Feb. 20, 1924 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lester Manor Va. DATE OF BURIAL 2-26 1924

20 UNDERTAKER Jno D Easton ADDRESS 916 [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 84004

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pazeras

(a) RESIDENCE NO. 2639 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth Grebliauckas Pazeras

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Andrew Pazeras

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Rinkevichy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) John Grebliauckas 425 S. Bond St.

15 FEB 20 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1 1924 to Feb. 18 1924

that I last saw him alive on Feb. 18 1924

and that death occurred, on the date stated above, at 4.10 p m.

The CAUSE OF DEATH* was as follows:

Nephritis, acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Paralysis, Septicaemia Not Memphis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 16, 1924

Was there an autopsy? No

What test confirmed diagnosis? Repeated urinalyses

(Signed) Jay Martin, M. D.

2/18. 1924 (Address) Union Mem. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Feb 21 1924
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S. Bond St.

(Jurgis Zagonis) (or Jurgis Z. Zagonis or Joris) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84005

CERTIFICATE OF DEATH. 4 181-06 84005

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 673 N. Fayette St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jurgis Zagonis (or Joris) (Jurgis Zagonis)

(Residence in Baltimore: No. 673 N. Fayette St. St.; yrs. ..... mos. ..... ds.)

att to

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Mar'd

6-DATE OF BIRTH, ... Don't Know ..... 1.....
(Month) (Day) (Year)

7-AGE, 42 about yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of industry, business, or establishment in which employed (or employer): 88

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country), " " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER, (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grebliauckas

(Address) 425 S. Paca St.

15-

Filed FEB 20 1924 ROBERT H. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation Illuminating Gas

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chron. Alcoholism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Tomasch M. D.
(Coroner.)

2-20 1924 (Address) 117 W Saratoga St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Feb 22, 1924

20-UNDERTAKER, John Grebliauckas — ADDRESS 425 S. Paca St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

- WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Soec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84006 ✓ D 84006

CERTIFICATE OF DEATH.

D 84006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Furtow

(a) RESIDENCE No. 2519 E. Biddle St— ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 27 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Weymouth Mass

PARENTS

10 NAME OF FATHER Alson Furtow

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Claire Mich

12 MAIDEN NAME OF MOTHER Julia Meno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bay City Mich

14 Informant Father (Alson Furtow) (Address) 2519 E Biddle St

FEB 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1924, to Feb. 19, 1924, that I last saw h alive on Feb. 19, 1924, and that death occurred, on the date stated above, at 8.50 p m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever (Malignant)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Myron G. Sull, M. D.

, 19 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemtry	Feb 20 1924
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

(Davis)

D 84007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84007

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 N Stricker ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis Elias Wains

(a) RESIDENCE No. 1025 N Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 16, 1923

7 AGE: Years | Months: 6 | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Lonza Wains

11 BIRTHPLACE OF FATHER (city or town) (State or country): Northumberland Va

12 MAIDEN NAME OF MOTHER Mamie Kinsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Northumberland Va

14 Informant (Address): Lonza Wains 1025 N Stricker

FEB 20 1924 Filed 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1924, to Feb 18, 1924.

that I last saw him alive on Feb 18, 1924,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia,

Uncomplicated,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter Dorsey, M. D.

(Address) 1400 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 20 1924

20 UNDERTAKER: Jam's W Chase Son

ADDRESS: 1400 Mosher

MARGIN RESERVED FOR BINDING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

1.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS AGE should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84008

CERTIFICATE OF DEATH.

H1 D 84008

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1101 Wilcox ST., 10 WARD)

2-FULL NAME Irene Mary Mooney

(a) RESIDENCE No. 1101 Wilcox ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Sngl.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Richard A. Mooney

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian A. Ellers

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Richard A. Mooney
(Address) 1101 Wilcox

15 Filed FEB 20 1924 19 Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14. 1924. to Feb 19. 1924.
that I last saw her alive on Feb 19. 1924.
and that death occurred, on the date stated above, at 9½ P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia
Mid. Starch = Empiric
Lig.

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W Bowles M. D.
1924 (Address) 709 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Febry 21 1924

20 UNDERTAKER Henry Horch Son — ADDRESS 120 E Lexington

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84009

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 St. Joseph's Hospital ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Waldman

(a) RESIDENCE NO. 1830 St. Durham ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary P. Waldman

6 DATE OF BIRTH (month, day, and year) July 19 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman RR

(b) General nature of industry, business, or establishment in which employed (or employer) Penn. 673

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James D. Mason Waldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs. Mary P. Waldman 1830 N Durham St

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

FEB 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-17, 1924, to 2-20, 1924 that I last saw him alive on 2-20, 1924 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis; 2 days

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-17-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J Norwood Wilson M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Feb 23 1924

20 UNDERTAKER Henry Horch Son ADDRESS 1301 E Fayette

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

✓ D 84016

D 84016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 Huntington Ave. St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Mc Cluskey

(a) RESIDENCE. No. 2127 Huntington Ave St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widow

5a ~~If married, widowed, or divorced~~ HUSBAND (or) WIFE of Robert Mc Cluskey

6 DATE OF BIRTH (month, day, and year) Aug 31st 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72-	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Jos. Wiesman 2127 Huntington Ave

FEB 20 1924 . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12th, 1924, to Feb. 18th, 1924, that I last saw h[illegible] alive on Feb. 18th, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of Left joint (Intracapsular)

Hypostatic Pneumonia (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel G. Ross, M. D.

, 19 (Address) 2904 Maryland Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 2-21-1924

20 UNDERTAKER H. C. Brannigan Son

ADDRESS 51 N. Edward St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84011

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 E Pratt ST. 3 WARD)

2-FULL NAME John Carpentieri

(a) RESIDENCE NO. 1105 E Pratt ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elveara Carpentieri

6 DATE OF BIRTH (month, day, and year) Sept 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Luigi Carpentieri

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Antonetta Carpentieri

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Antonetta M Carpentieri
(Address) 1105 E Pratt

15 Filed FEB 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1924, to Feb. 18, 1924, that I last saw him alive on Feb 18, 1924, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Saml Lampert, M. D.

19 (Address) 1634 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Febuary 1924
20 UNDERTAKER Wendell Dypel & Son	ADDRESS 378 Nmn

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84012

CERTIFICATE OF DEATH.

D 84012

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 W Lafayette Ave. WARD 14)

2-FULL NAME Maggie S Gilmore

(a) RESIDENCE NO. 616 W Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Gilmore

6 DATE OF BIRTH (month, day, and year) Sept 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) General 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Willis Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cathie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Agnes Hammond

(Address) 616 Roland Ave

15 FEB 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 19, 1924, that I last saw her alive on Feb 19, 1924, and that death occurred, on the date stated above, at 3:00 A m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 10 ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Howard Woodbridge, M. D.

2-20-1924 (Address) 802 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Feb 22 1924

20 UNDERTAKER Emma E Wright & H McCary ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

D 84013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84013

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1348 Calhoun ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Dorsey

(a) RESIDENCE NO. 1348 Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) ? 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Nolan Atkinson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)

14 Informant Sarah E. Ellis
(Address) 1348 Calhoun St

15 Filed FEB 20 1924, Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Feb 19, 1924, that I last saw h[illegible] alive on Feb 18, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Date of

Was there an autopsy? -

What test confirmed diagnosis?

(Signed) E. Wallace Frey, M. D.

2/20, 1924 (Address) 1928 Pennsylvania Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star DATE OF BURIAL Feb 21 1924

20 UNDERTAKER Samuel W. Chase Son ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84014

CERTIFICATE OF DEATH.

D 84014

1-PLACE OF DEATH

City of BALTIMORE: (No. 1709 Lemmon St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Martin

(a) Residence No. 1709 Lemmon St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 9 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: ~~Male~~ Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Oscar Martin

6-DATE OF BIRTH (month, day and year): May 11-1872

7-AGE: 51 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 027

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Balto, Md

PARENTS.

10-NAME OF FATHER: Henry Gast

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Mary Mack

(Address): 1414 Ramsay St

15- Filed FEB 20 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 18 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924 to Feb 18, 1924

that I last saw her alive on Feb 18, 1924

and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH* was as follows:

Labor Premature

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Walter Dick M. D.

2/20, 1924 (Address) 547 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery

DATE OF BURIAL, Feb 21st 1924

UNDERTAKER, F. B. Keppler

ADDRESS 2236 Eutaw ave

MARGIN RESERVED FOR BINDING.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84015

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo W. Paynter

(Residence in Baltimore: No. 123 Patapsco St Milford St., 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Sgle

6-DATE OF BIRTH: Feb (Month) 15 (Day) 1871 (Year)

7-AGE: 53 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dairyman
(b) General nature of industry, business, or establishment in which employed (or employer): Dy

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Thos Paynter

11-BIRTHPLACE OF FATHER. (State or Country): England

12-MAIDEN NAME OF MOTHER: Hagner-

13-BIRTHPLACE OF MOTHER. (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Tambut

(Address) 1627 N. Fulton Ave

15- Robert F. Harrison

192.....

FEB 20 1924 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 19 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

a few hours

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Block

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Bond M. D. (Coroner.)

2-20 192 4 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL Feb 22 1924

20-UNDERTAKER. H. Maurice Rontsen ADDRESS Saratoga

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84016

CERTIFICATE OF DEATH.

100 D 84016

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St., 7 Ward)

2-FULL NAME Dorothy Inez Duncan

(a) RESIDENCE No. 1025 Rutland Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28th 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Charles Duncan 1025 Rutland Ave

15 Robert P. Harrison, Registrar

FEB 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924 to Feb. 17, 1924.

that I last saw her alive on Feb 17, 1924,

and that death occurred, on the date stated above, at 7:10 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2/7. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laudon Park.

DATE OF BURIAL Feb 21st 1924

20 UNDERTAKER Leo G. Cook

ADDRESS Northborough

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 - M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84017

CERTIFICATE OF DEATH.

90

D 84017

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 Harford Ave ST., 10 WARD)

2-FULL NAME Edward V. McSweeney

(a) RESIDENCE No. 900 Harford Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guard Ct

(b) General nature of Industry, business, or establishment in which employed (or employer) City Jail 6 yr

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John McSweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank McSweeney (Address) 523 E 21st St

15 Filed FEB 20 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1923 to Feb 19 1924, that I last saw him alive on Feb. 18 1924, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis - Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure & urine

(Signed) Gustav H. Wolbrecht, M. D.

Feb 19 1924 (Address) 1120 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cem	Feb 25th 1924
20 UNDERTAKER	ADDRESS
Leo J. Cook	North & Harford

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 223 N. Collington Ave 6 St. ..... Ward)

Registered No. 84018

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Pokler

(a) Residence No. 223 N. Collington Ave St. ..... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louise R. Pokler

6-DATE OF BIRTH (month, day and year) Sept 6 1859

7-AGE. 64 yrs. 5 mos. 12 ds.

If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Detective retired 6/

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Balto

PARENTS.

10-NAME OF FATHER, Herman Pokler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ann Hannibal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Kentucky

14- (Informant) Louise R. Pokler

(Address) 223 N. Collington Ave

15- Filed ..... 192 ..... Registrar.

Robert F. Harrison, Burial Permit Clerk

FEB 20 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 16 1924 to Feb 17 1924

that I last saw h[illegible] alive on Feb 16 1924

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Nephritis (Duration) unknown

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm Lorman M. D

(Address) 2 W Lafayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL. Feb 21 1924

20-UNDERTAKER. Wm J[illegible] Keen Sons ADDRESS Norfolk Va

MARGIN RESERVED FOR BINDING.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 84019

REGISTERED NO. C 74-00

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 28 W. 25th ST.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alvina Shipley Sturs Ridgely

(Residence in Baltimore: No. 28 Kennedy Heights St.: 79 yrs. 7 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH September 12, 1845 (Month) (Day) (Year)

7 AGE 79 yrs. 7 mos. 10 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Living at home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9 BIRTHPLACE (State or country) Howard County Md.

PARENTS

10 NAME OF FATHER Caleb Shipley

11 BIRTHPLACE OF FATHER (State or country) Howard Co.

12 MAIDEN NAME OF MOTHER Hobbs

13 BIRTHPLACE OF MOTHER (State or country) Howard Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. S. Parkhurst

(Address) 1410 Park Ave

15 FEB 20 1924

Robert P. Harrison, M.D.

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 19th, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from February 19th, 1924, to Feby 19th 1924

that I saw h[illegible] alive on Feby 19th, 1924

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
with hemiplegia of left
side (Duration) yrs. 0 mos. 10 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Alice S. Parkhurst M. D.

Feby 19, 1924 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ark Grove Cem Hyatts	F. C. 21/24
20 UNDERTAKER	ADDRESS
Wm Fickardson Sons	North Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84020

CERTIFICATE OF DEATH.

90 D 84020

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Madison Ave ST. 14 WARD)

2-FULL NAME Susan Elizabeth Dwinelle

(a) RESIDENCE No. 1506 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
(or) WIFE of Dr. James E Dwinelle

6 DATE OF BIRTH (month, day, and year) Feb. 21st. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Wellsleger

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Whitmore

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Fleetwood C Kontz
(Address) 509 S Lurzerne Ave.

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1924, to Feb. 19, 1924, that I last saw h.. alive on Feb. 19, 1924, and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Heart disease (Acute myocarditis)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy - hemiplegia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs + symptoms

(Signed) J. F. C. Tunnell, M. D.

Feb. 20, 1924 (Address) 1226 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 2/22/2419

20 UNDERTAKER: H. E. Hughes 424 N Broadway — ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 84021

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1544 N. Washington ST.: 8 WARD)

2-FULL NAME Conrad H. Dare

(a) RESIDENCE. No. 1544 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or, WIFE of) Elizabeth Dare

6 DATE OF BIRTH (month, day, and year) 12, 22, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christoph Dare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Baltzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Mrs. Elizabeth Dare

(Address) 1544 N. Washington St.

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from February 10 1924 to February 19 1924

that I last saw him alive on February 19 1924

and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(Hemeplegia)

Duration yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles H. A. Meyer, M. D.

2/20 1924 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Feb 21 1924
20 UNDERTAKER	ADDRESS
Frank A. Fink	9104 Gay St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 84022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84022

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Theodosia Leddy

(a) RESIDENCE. No. Cinquitti St & Rockland Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-13-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER William Leddy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Irelands

12 MAIDEN NAME OF MOTHER Helen Reardon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Sister Mary Dionisia

(Address) Notre Dame Cinquitti St

15 FEB 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 19 - 1924

17

I HEREBY CERTIFY, That I attended deceased from July 18, 19 24, to July 19, 19 24, that I last saw h.e alive on July 19, 19 24, and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left Hemiplegia

48 hours
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. J. Kenny, M. D.

2-21, 1924 (Address) 1106 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb 22 1924
20 UNDERTAKER	ADDRESS
Frank A. Fink	810 E Lexington

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84023

CERTIFICATE OF DEATH.

100-002

D 84023

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 4605 Eastern St., No. WARD)

2-FULL NAME Mary Kaiaridas

(a) RESIDENCE No. 4605 Eastern ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/25/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓		1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. md
(State or country)

PARENTS

10 NAME OF FATHER N. Kaiaridas

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Estella Kaiaridas

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant N. Kaiaridas
(Address) 4605 Eastern Avenue

15 FEB 21 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap Pneumonia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 7 yrs. 2 mos. ds.

(Signed) Geo Elliott Bates M. D.
(Coroner.)

Feb 21, 192 (Address) 1143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 2/24 1924

20 UNDERTAKER George J. Ruth — ADDRESS 1305 Harford Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84024

CERTIFICATE OF DEATH.

101-001

D 84024

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5006 Augusta Ave. St., Hamilton 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irving L. Webster

(a) Residence No. 5006 Augusta Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Raver

6-DATE OF BIRTH (month, day and year) Nov. 20, 1870

7-AGE.	If LESS than 1 day,
53 yrs. 2 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn. Railroad

9-BIRTHPLACE (city or town) (State or Country), Dorcester Co. Md.

PARENTS.

10-NAME OF FATHER, William Webster

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret -----

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant) Mrs. Annie Webster

(Address) 5006 Augusta Ave.

15- Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 18-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 12 1924 to Feb 18 1924

that I last saw h alive on Feb 18 1924

and that death occurred, on the date stated above, at 11.00 p.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis & Enlarged heart (Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E. Smith M. D.

2/19, 1924 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cemetery	2/21, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84025

100-001 D 84025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. #12 S 1st Brooklyn 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Schatz

(a) Residence No. #12 S 1st St Brooklyn Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	—

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6-DATE OF BIRTH (month, day and year) Jan 12/24

7-AGE. ... yrs. 1 mos. 7 ds. If LESS than 1 day, ... hrs. or. ... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work — —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm Schatz

11-BIRTHPLACE OF FATHER (city or town) Balto.
(State or Country),

12-MAIDEN NAME OF MOTHER, Stella Jungeck

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country),

14- (Informant) Wm Schatz

(Address) #12 S 1st St.

15- FEB 21 1924 Burial Permit Clerk.
Registrar.

ROBERT R. KRAUTER.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 15, 1924, to Feb 19, 1924, that I last saw h... alive on Feb 19, 1924, and that death occurred, on the date stated above, at 9-30 a.m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Eczema

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas T Moore M. D.

. 1924 (Address) Brooklyn Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cem.	2/21, 1924
20-UNDERTAKER,	ADDRESS
Fred J Krauss & Son	763 Hanover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84026 — 129 — D 84026

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 864 West 37th ST., (13) WARD)

2-FULL NAME James Orem

(a) RESIDENCE No. 864 West 37 ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Orem

6 DATE OF BIRTH (month, day, and year): Nov 17-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 046

(b) General nature of industry, business, or establishment in which employed (or employer): Mill Operator

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: John E. Orem

(Address): 864 West 37th St.

Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 7th, 1924, to Feb 19th, 1924,

that I last saw him alive on Feb 19th, 1924,

and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows:

Chron Endo + Myocarditis

& Chron Inter Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Odema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) Alexander Lerman M. D.

2/21, 1924 (Address) 856 W 36 St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Feb 22 1924

UNDERTAKER: GRENOWETH & SON,

ADDRESS: 3617 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84027

CERTIFICATE OF DEATH.

90 D 84027

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Light St ST., 23 WARD)

2-FULL NAME Martha J Wood

(a) RESIDENCE NO. 1714 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James L Wood

6 DATE OF BIRTH (month, day, and year) Aug 16 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Parrish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm E Wood

(Address) 1714 Light St

15 FEB 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20th 1924

17 I HEREBY CERTIFY, that I attended deceased from Jan. 29th 1924 to Feb. 20th 1924

that I last saw her alive on Feb. 19th 1924

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Regurgitation

of Heart

(duration) — yrs. — mos 22 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Kleibel M.D.

2/20 1924 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cross Road. DATE OF BURIAL Feb 23 1924

UNDERTAKER J. ROSENBERGER & SON, 3617 CHESTNUT AVE.

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bl...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84028 Katherine — 46 — D 84028

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2060 Plymouth ST Ave WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Smith

(a) RESIDENCE. No. 2060 Plymouth Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earnest Smith

6 DATE OF BIRTH (month, day, and year) Jan 20 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Laarer (Address) 2060 Plymouth

15 [illegible] FEB 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st 1923 to Feb 20th 1924 that I last saw h[illegible] alive on Feb 19th 1924 and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma, (of pelvis and abdominal organs) (Primarily Uterus and Ovary)

(duration) ... yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Above

(duration) ... yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb 14th

Was there an autopsy? yes

What test confirmed diagnosis? Clinical, surgical & pathological

(Signed) H. A. Fitzell M. D.

Feb. 19 24 (Address) 1527 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Feb 1924

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 84029
Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 3625 Maple ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Vaught

(Residence in Baltimore: No. 3625 Maple ave St.; yrs. 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

6-DATE OF BIRTH, ... Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Samuel Vaught

11-BIRTHPLACE OF FATHER, (State or Country) Va

12-MAIDEN NAME OF MOTHER, Sarah Trauful

13-BIRTHPLACE OF MOTHER, (State or Country) Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Baggerly

(Address) 3625 Maple ave

FEB 21 1924

ROBERT R. KRAUTER,
Clerk Permit Bureau Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19 24
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Alcoholism

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey M. D.
(Coroner.)

Feb 19 1924 (Address) 363 W. Lanvale

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Cemetery DATE OF BURIAL, Feb 21 1924

20-UNDERTAKER, J. J. BRENNAN & SON ADDRESS 3617 CHESTNUT AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84030

CERTIFICATE OF DEATH.

X 49

D 84030

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Rockdale Ave ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R. Weedon

(a) RESIDENCE No. 5 Rockdale Ave ST., ... WARD Church Hill, Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Wm. H. H. G. Weedon

6 DATE OF BIRTH (month, day, and year) April 21 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Island, Md.
(State or country)

PARENTS

10 NAME OF FATHER William S. Thompson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Groom

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Mary E. Grace
(Address) 5 Rockdale Ave.

FEB 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1923, to Feb. 20, 1924.

that I last saw her alive on Feb. 19, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Sarcoma of rt shoulder.

(duration) 4 to 5 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Church Hill, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

2/20, 1924 (Address) 13 Bel Air Rd., Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Hill Maryland

DATE OF BURIAL Feby 21 1924

20 UNDERTAKER Chas. D. Black

ADDRESS 742 W. Northave

Spec—12-23-21—E.B.R.S.—400 Bks.

Haden

D 84031 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH.

80 D 84031 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital 43 St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Haden

(a) Residence No. 7578 McCulloh St Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE. White | 5-Single, Married, Widowed or Divorced (Write the word) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 17 1924

7-AGE. ..... yrs. ..... mos. 3 ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto. Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Edward Haden

11-BIRTHPLACE OF FATHER (city or town) Phila Pa
(State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Tillie Schapiro Not Known

13-BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or Country), Not Known

14- Edward Haden
(Informant).....
(Address) 7578 McCulloh St.

15- Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 20 '24

17- I HEREBY CERTIFY, That I attended deceased from Feb 17 1924 to Feb 20 1924

that I last saw h.r alive on Feb 20 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. 2 ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physician Diagnosis

(Signed) H W Harper M. D

19 (Address) St. Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cemetery	Feb. 21, 1924
20-UNDERTAKER.	ADDRESS
Jack Levin	1499 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Cor.—1-12-21—M&T—100 Blks.

D 84032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84032

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 874 ST. Johns Ct. ST., 10 WARD)

REGISTERED NO. 78

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Fletcher

(a) RESIDENCE No 874 St. Johns Ct ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	xxxxx single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryla nd

PARENTS

10 NAME OF FATHER Wm E. Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) D.C.

12 MAIDEN NAME OF MOTHER Mary M.Siers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Evelyn Ball
(Address) 113 Colvin St

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) History of epilepsy (duration) yrs. mos. ds.

(Signed) J. S. Waters, M. D. (Coroner.)

Feb 20/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 21 192 4
20 UNDERTAKER	ADDRESS
Joseph T. H. Rochester	1483 Hoffman St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

TYPE

Spec—12-23-21—E.B.R.S.—400 Bks.

2757 W. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

84033 D 84033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2859 West North St., 15 Ward) Registered No. 90

2-FULL NAME Ella True Thomas

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2859 West North St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Joseph H Thomas

6-DATE OF BIRTH (month, day and year) Nov 4-1851

7-AGE, 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). St Michaels Md

PARENTS.

10-NAME OF FATHER. Wm P. Blades

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Caroline Seth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant) Harriet H. Thomas

(Address) 3203 West North Ave

15-Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-18-24

17- I HEREBY CERTIFY, That I attended deceased from May 8, 1923, (Feb 18, 1924, that I last saw h~~er~~ alive on Feb 18, 1924, and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic ocu dutis

Apnea

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H H Cullen M. D.

2/19/24 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, Feb 21, 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ASK FOR DOCUMENT

Spec– 12-23-21– E.B.R.S.—400 Bks.

D 84034

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 84034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2010 Ellsworth St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna Rezek

(a) Residence No..... 2010 Ellsworth St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Rezek

6-DATE OF BIRTH (month, day and year) June 9 1852

7-AGE, 71 yrs. 8 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS:

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not known

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not known

11- (Informant) Mary Rezek

(Address) 2010 Ellsworth Ave

FEB 21 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb-19/24

17- I HEREBY CERTIFY, That I attended deceased from 2-17 19 24 to Feb 19 19 24

that I last saw h[illegible] alive on ..... 19....

and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) F. Friedrich M. D.

(Address) 800 N Wolfe St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Feb 22, 1924
20-UNDERTAKER.	ADDRESS
Frank Gordon	1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84035

CERTIFICATE OF DEATH.

38

D 84035

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. St Josephs Hos. ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Herman Mack

(Residence in Baltimore: No. 344 S Robinson St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sing

6-DATE OF BIRTH, Mar (Month) 15 (Day) 1893 (Year)

7-AGE, 30 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Brooklyn

PARENTS.

10-NAME OF FATHER, Frederick Mack

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Melvina Gast

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Fred Mack

(Address) 3501 E Balto St

15- FEB 21 1924 Filed ROBERT R. KRAUTER, Burial Permit Clerk..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19/24 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Endocarditis-Myo-Carditis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Chr. Alcoholism -Syphil

(Duration).....yrs.....mos.....ds.

(Signed) J S H (Coroner.) .....M. D.

Feb 21/24 (Address) 508 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn

DATE OF BURIAL, Feb 23 19.2

20-UNDERTAKER Peter Nicolaus

ADDRESS 2060 Easter

Cor.—1-12-23—M&T—100 Bks.

D 84036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced Dead at St. Joseph Hospital ST., 10 WARD)

REGISTERED NO. 181-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Max Schoenwisner

(a) RESIDENCE No 704 E. Chase St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred America 40 yrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna (Porst) Schoenwisner

6 DATE OF BIRTH (month, day, and year) Feb 13/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Anna Schoenwisner

(Address) 112 Cherry St. Raspberg, P.O.

15 FEB 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation Accidental- Heating Stove valve left partly open.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) ....yrs. ....mos. ....ds.

(Signed) [signature], (Coroner), M. D.

Feb 20/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Feb. 21 1924
20 UNDERTAKER Richard F. Curley.	ADDRESS 1108 Guilford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 84037

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2750 Wilkens ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Christian Hiltz .....

(a) Residence No. 2750 Wilkens ave St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude E. Hiltz

6-DATE OF BIRTH (month, day and year) May 19, 1860

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John R. Hiltz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Krause

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Mr. John R. Hiltz

(Address) 517 S. Brunswick ave

15- FEB 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 20, 19 24, to Feb 20, 19 24, that I last saw h.. alive on Feb, 19 24, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Glassman M. D

Feb 21, 19 24 (Address) 268 N Wolfe ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London — DATE OF BURIAL, Feb. 23, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 East North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Brown

D 84038 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84038

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2123 Boyd St. St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Marie Brown

(a) Residence No. 2123 Boyd St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 6, 1912

7-AGE, 11 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas. Hm Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary M Klein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Mrs. Mayer Brown

(Address) 2123 Boyd St

15- FEB 21 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1924 to Feb. 20, 1924.

that I last saw her alive on Feb 19, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw V. Coolahan, M. D.

2/20/1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, Feb 23, 1924

20-UNDERTAKER, Hm Cook ADDRESS 501 S Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 N. Gilmor ST., 16 WARD)

2-FULL NAME John Edward Pratt

(a) RESIDENCE NO. 1137 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Pratt

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: 45 Years + Months + Days +

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Hamburger & Co. Broadway Baltimore.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Elijah Pratt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Caroline Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary E. Pratt

(Address): 1137 N. Gilmor St.

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Feb 19, 1924, that I last saw him alive on Feb 19, 1924, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Oedema of lungs. Mit

(duration) — yrs. one mos. 9 ds.

CONTRIBUTORY (Secondary): Dilatation of Heart.

(duration) yrs. One mos. 9 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark, M. D.

(Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2-22 1924

20 UNDERTAKER: David Easter

ADDRESS 916 Pa ave

Spec—12-23-21—E.B.R.S.—400 Bks.

84040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84040

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asbury Shall

(a) Residence No. 223 S Spring Street St., Ward.....

(Usual place of abode) 215

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) S. Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1841

7-AGE. 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer 0440

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Illinois

PARENTS.

10-NAME OF FATHER, Charles Shall

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Illinois

12-MAIDEN NAME OF MOTHER, Penny Shall

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Illinois

14-

(Informant) Boy Nurse

(Address) J Hosp

15-

Filed FEB 21 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 16 1924 to Feb. 16 1924 that I last saw him alive on Feb. 16 1924 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

General Anasarca

Auricular Fibulation

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Faulk M. D

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	2-22 1924
20-UNDERTAKER.	ADDRESS
David Garson	916

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.- 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84041

CERTIFICATE OF DEATH.

11-001

D 84041

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

(a) CITY OF BALTIMORE: (No. 1214 Eutaw Pl ST., 20 WARD)

2 FULL NAME Mattie Cynthia Collard

(a) RESIDENCE No. 1214 Eutaw Pl ST., WARD

(Usual place of abode)

(b) City or town where death occurred Balto yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

4 SEX | COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word)

Female | White | Married

5a If married, widowed, or divorced (or) Husband of Chas E Collard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

4 | | | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Elias Dodd

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Martha Allen

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Chas E Collard (Address) 1214 Eutaw Pl

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

FEB 21 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Feb 20, 1924, that I last saw h[illegible] alive on Feb 20, 1924, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 5 days yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb. 23 1924

20 UNDERTAKER: Wilson W. Shives — ADDRESS: 1018 Edmondson Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 00

D 84042

D 84042

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 Burgundy ST., 21 WARD)

2-FULL NAME Pearl P Wheelton

(a) RESIDENCE NO. 1106 Burgundy St., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Febry 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leonard J W Shelton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Durall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Leonard J W Shelton
(Address) 1106 Burgundy St

15 FEB 21 1924 ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 20 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feby. 15, 1924 to Feby 20, 1924 that I last saw him alive on Feby 18, 1924 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Auto bronchitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M D Shipinger, M. D.

2/20 1924 (Address) 687 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	2/21 1923
20 UNDERTAKER Edward Jonson	ADDRESS 1217 N Gilmor St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 84043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84043

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2904 Parkwood ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Kalmans

(a) Residence No. 2904 Parkwood ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 14-1915

7-AGE. 8 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Meyer Kalmans

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Sarah Gerber

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant) Jack Lewis
(Address) 1439 E Balto St

15- FEB 21 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-21-24

17- I HEREBY CERTIFY, That I attended deceased from Jan - 1923; to Feb. 20, 1924.
that I last saw him alive on Feb. 20, 1924.
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 1 yr. (one-year) mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(Duration) 4 yrs. 1/2 mos. ds.

18-Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? — No

(Signed) Joseph W. Kelly M. D.
, 19 (Address) 910 Brooks Lane

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Hebrew Rosedale	2-21 19.24
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1439 E Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84044

REGISTERED NO. 31 D 84044

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 3 WARD)

2-FULL NAME Fred Miller

(a) RESIDENCE NO. 919 Granby st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Evan Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Shroder ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M.T.H.

15 FEB 21 1924 August H. Kraeuter, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1924, to Feb. 19, 1924, that I last saw him alive on Feb. 19, 1924, and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray. Sputum

(Signed) L. A. Lall, M. D.

2-19-24, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Dept. of Health, Per. Wm. E. WOODALL

ADDRESS

FEB 21 192

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84045

CERTIFICATE OF DEATH.

100-001

D 84045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 Wilkens ave ST., 20 WARD)

2-FULL NAME Helen Pless

(a) RESIDENCE NO. 2402 Wilkens ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. 2 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced, (write the word)~~
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Pless.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungaria

12 MAIDEN NAME OF MOTHER Susie Kiefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungaria

14 Informant George Pless

(Address) 2402 Wilkens Ave.

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 18, 1924, to Feby 21, 1924, that I last saw her alive on Feby 20, 1924, and that death occurred, on the date stated above, at 3 a, m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Dill, M. D.

2/24 1924 (Address) 1433 Woodland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb. 22, 1924.

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3107 Fredk. Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84046

CERTIFICATE OF DEATH.

4 1924

D 84046

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Hardy

(Residence in Baltimore: No. 656 W. Saratoga St. St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col'd

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. ..... (Month) 1898 (Day) 1 (Year)

7-AGE. 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

9-BIRTHPLACE, (State or Country). Married NC

PARENTS.

10-NAME OF FATHER. Mack Hardy

11-BIRTHPLACE OF FATHER. (State or Country). NC

12-MAIDEN NAME OF MOTHER. Isabella Mack

13-BIRTHPLACE OF MOTHER. (State or Country). NC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Hardy

(Address) 656 W Saratoga

15-

Filed FEB 21 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 16 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound in abdomen

(Duration) ..... yrs. 4 hrs. 4 mins. 0 ds.

CONTRIBUTORY (Secondary) Shot by Unknown Negro

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. R. Samuel M. D.
(Coroner.)

2-21 1924 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Enfield NC — DATE OF BURIAL. Feb 21 1924

20-UNDERTAKER. R. L. Gross — ADDRESS Woodsdale

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84047

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1623 E. Eager ST., 7 WARD)

2-FULL NAME George E. Brentine

(a) RESIDENCE NO. 1623 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	61	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 020

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Seraphine Brentine

11 BIRTHPLACE OF FATHER (city or town) Switzerland (State or country)

12 MAIDEN NAME OF MOTHER Mary A. Vogel Luter

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Mary Beran (Address) 1623 E Eager st

15 FEB 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febuary 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to Feb 21, 1924, that I last saw h[illegible] alive on Feb. 20 1924 and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease (duration) Chronic Insufficiency 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Fetch M. D.

2/21 1924 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral cemetery DATE OF BURIAL Febuary 23 1924

20 UNDERTAKER Henry Storch Son ADDRESS 1301 E Eager st

B 84048

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 84048

CERTIFICATE OF DEATH.

(Typewrite) 199

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. on Street on way to Hospital No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Fuchs or (Fo[illegible])

(Residence in Baltimore: No. 734 S. 3rd St. St.; yrs. 19 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. March 5 (Month) (Day) 1903 (Year)

7-AGE. 20 yrs. 10 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Usher
(b) General nature of industry, business, or establishment in which employed (or employer): at Theatre.

9-BIRTHPLACE, (State or Country). Dayton Kentucky

PARENTS.

10-NAME OF FATHER. August Fuchs

11-BIRTHPLACE OF FATHER, (State or Country). Ger.

12-MAIDEN NAME OF MOTHER. Catherine Huber

13-BIRTHPLACE OF MOTHER, (State or Country). Louisville Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Fuchs.

(Address) 734 S. 3rd St

15- FEB 21 1924

Registrar. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 18 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or ~~inquiry~~.) thereon and from the evidence obtained by said Inquest, autopsy or ~~inquiry~~.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. Don't Know mos. ds.

CONTRIBUTORY (Secondary) an attempted abortion

(Duration) yrs. mos. ds.

(Signed) H R Gorsuch M. D. (Coroner.)

2-21 1924 (Address) 117 W Saratoga St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Hunt Co. DATE OF BURIAL. Feb. 22 1924

20-UNDERTAKER. Lilly & Zirkin ADDRESS 403 S. Wolfe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. Municipal Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Dickenson

(a) Residence No. Wilson Avenue (Ground) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colred

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Wm. Dickenson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland.

14- (Informant)

(Address) Municipal Hospital

15- Record

ROBERT R. KRAUTER, Registrar.

FEB 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 4, 1924, to Feb. 18, 1924, that I last saw him alive on Feb. 18, 1924, and that death occurred, on the date stated above, at 3-45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem. DATE OF BURIAL, Feb 21, 1924

20-UNDERTAKER, Mrs R A Elliott ADDRESS 1725 Ashland Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

Desper

D 84050 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84050

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 N. Pont St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Horace Desper

(a) Residence No. 1122 N. Pont St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1870

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Martha Harley

(Address) 1122 Pont St

15- Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Feb. 19, 1924, that I last saw h.. alive on Feb. 19, 1924, and that death occurred, on the date stated above, at 5-P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Ex.

(Signed) R. G. Thomas M. D.

Feb 21, 1924 (Address) 1534-24 N. Carey

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cashmere Cemetery — DATE OF BURIAL. Feb. 24, 1924

20-UNDERTAKER Mrs. K. A. Elliott — ADDRESS 1726 Pinkland Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84051

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

2-FULL NAME John Waters

(a) RESIDENCE NO. 850 McKim ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records (Address)

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-10 .1924. to 2-16 .1924

that I last saw him alive on 2-16 .1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Broad, M. D.

2-18. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Feb 20, 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

Spec—12-23-21—E.B.R.S.—400 Blks. (Corrected Copy received 12-30-24)

Municipal Rosario

D 84052

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Dr Jones has a letter in this case)

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If denth occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maccione Rosario or Rosario Maccione

(a) Residence No. 124 W. Camden St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Sept 20, 1895 ~~1896~~

7-AGE,	If LESS than 1 day,
28 yrs. 5 mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, John Rosario

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, ...

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Municipal Hospital Records

(Address) .....

15-

Filed....., 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-20-24

17- I HEREBY CERTIFY, That I attended deceased from 1-7....., 1924, to 2-20....., 1924, that I last saw him alive on 2-20....., 1924, and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Subacute Endocarditis (Streptococcus Viridans); Mitral and Aortic Insufficiency; Myocardial Insufficiency (Duration) ....yrs. 15 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

.....(Durntion) ....yrs. ....mos. 6 ...ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Path & Autopsy

(Signed) Claude S. Howard, M. D.

2-21-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER,	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Rosalio Mayaroni)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84052

CERTIFICATE OF DEATH.

90 D 84052

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mayaroni Rosalio

(a) Residence No. 124 W. Camden St., Ward:

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Sing

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1896

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Peddler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, John Rosalio

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Municipal Hospital Records

(Address)

15- Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-20-24

17- I HEREBY CERTIFY, That I attended deceased from 1-7 1924 to 2-20 1924

that I last saw h[illegible] alive on 2-19 1924

and that death occurred, on the date stated above, at 2[illegible]5 a.m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis (Streptococcus Viridans)

Myocardial Insufficiency (Duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Thomas M. D

2-21 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Loudon Park Cemetery	Feb 21 24

20-UNDERTAKER, ADDRESS

A. Mariani Laurel Saratoga 5160

N. B.—WRITE PLAINLY; W[illegible] INFALLING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84053

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 84053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hamill

(a) Residence No. 527 W Lexington St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 4th 1839

7-AGE. 85 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas Hamill

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Hamill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Municipal Hospital Records

(Address).....

15- FILED FEB 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-18-24

17- I HEREBY CERTIFY, That I attended deceased from 2-5-24 19..... to 2-18 19 24

that I last saw him alive on 2-18 19 24

and that death occurred, on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Bronco-Pneumonia

(Terminal).....(Duration).....yrs.....mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Sym

(Signed) Claude B. Grace M. D

2-20 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cemetery	Feb 21 1924

20-UNDERTAKER. J. Maurice Poulson ADDRESS 56 Greene Saratoga

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PRESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Rks.

D 84054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84054

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3030 Belmont St. 46 WARD)

2-FULL NAME Nellie. J. Klages

(a) RESIDENCE No. 3030 Belmont St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Klages

6 DATE OF BIRTH (month, day, and year) Feb 14 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	44	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm H. Shedinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ida Kaul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Andrew Klages

(Address) 3030 Belmont Ave

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924.

17

I HEREBY CERTIFY, That I attended deceased from July — 1923 to Feb - 20 1924.

that I last saw h[illegible] alive on Feb 19th 1924.

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

2-24, 1924 (Address) 7002 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 23 1924

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 2175 Pac

Cor.—1-12-23—M&T—100 Bks.

D 84055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84055

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH near Fleet St

CITY OF BALTIMORE, (No.) St. Paul St. Pratt Lib #19 ST., WARD)

2-FULL NAME Heudbyke. Ornstein

(a) RESIDENCE No. 1734 Alice Anne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? 26 yrs. 6 mos. 29 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresia Ornstein

6 DATE OF BIRTH (month, day, and year) July 22-1865.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor Pratt Library
(b) General nature of industry, business, or establishment in which employed (or employer) Branch 19.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Breczany, Poland.

PARENTS

10 NAME OF FATHER ? Ornstein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Teresa Ornstein (wife)
(Address) 1734 Alicanna St.

15 Filed FEB 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(Signed) H. S. Wales, M. D.
(Coroner.)

Feb 26, 192 (Address) 1420 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL Feb. 22 1924

20 UNDERTAKER M. F. Sadowski, ADDRESS 905 S. Am St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Dekowski ✓

D 84056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 84056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Hudson ST., 1 WARD)

2-FULL NAME Cecelia Dekowska

(a) RESIDENCE NO. 2702 Hudson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 2 mos. 4 ds. How long in U. S., If of foreign birth? 26 yrs. 2 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Dekowska

6 DATE OF BIRTH (month, day, and year): Dec 5 - 1901

7 AGE — Years: 22 — Months: 2 — Days: 4 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Gardyluski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Julia Jarmuszewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Joseph Dekowski. (Address): 2702 Hudson St.

15 FEB 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/19/24

17 I HEREBY CERTIFY, That I attended deceased from 2/17/24, to 2/19/24, that I last saw h[illegible] alive on 2/17/24, and that death occurred, on the date stated above, at 2.15 P.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Chronic Tonsilitis

Pulmonary Tuberculosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Raymond St Fisher, M. D.

, 19 (Address) 501 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. — DATE OF BURIAL: Feb. 23 1924

20 UNDERTAKER: M. J. Sadowski. — ADDRESS: 705 S Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 84057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84057

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Eagle ST., 20 WARD)

2-FULL NAME Ruth Pollard Thomas

(a) RESIDENCE NO. 2112 Eagle ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3. 1923

7 AGE: Years ... Months 7 ... Days 13 ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Henry A Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Martha Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mrs Thomas
(Address) 2112 Eagle St

15 Filed FEB 21 1924 19 ROBERT L. KRAUTH Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20. 24

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1924, to Feb 20, 1924, that I last saw him alive on Feb 20, 1924, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ... yrs. ... mos 6 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

Feb 20 24 (Address) 222 Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Feb. 22 1924

20 UNDERTAKER: George L Schwab — ADDRESS: 2101 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 84058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84058

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Ostend ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Hearn.

(a) RESIDENCE NO. 117 E Ostend. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 18 1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) 03 06

(c) Name of employer Jerry T. Pearre

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John H. Hearn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Cypse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Hearn

(Address) 117 E Ostend St

Filed FEB 21 1924, 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 20 1924

I HEREBY CERTIFY that I attended, deceased from Feb 17, 1924, to Feb 19, 1924.

that I last saw h alive on Feb 19, 1924.

and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Interstitial nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

~~Was there an autopsy?~~ No.

What test confirmed diagnosis?

(Signed) J. W. Schumann M. D.

(Address) 119 E. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross & Co.	2-23 1924
20 UNDERTAKER	ADDRESS
A B Hartz	115 E West St

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84059

CERTIFICATE OF DEATH.

100-001 ✓ 84059

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 W Lexington ST., 4 WARD)

2-FULL NAME Marie Truske

(a) RESIDENCE No. 746 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Henry Truske

6 DATE OF BIRTH (month, day, and year) 12-29-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prussia

PARENTS

10 NAME OF FATHER Louis Rudolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Henry Truske

(Address) 746 W Lexington St

15 Filed FEB 21 1924 Robert P. Harrison, Registrar

Daniel Ferait Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1924, to Feb 20, 1924, that I last saw h[illegible] alive on Feb 19, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Old age

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon Kenneker, M. D.

2-21, 1924 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cem	2-22 1924

20 UNDERTAKER McCleaf & Ponder ADDRESS 1600 Washington Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

D 84060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84060

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 N Pine st St., 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ellen Connelly

(Residence in Baltimore: No. 117 N Pine st St.; 9 yrs., ... mos. ..... ds.)

THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Don't know ..... 1.....
(Month) (Day) (Year)

7-AGE. 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country), Va.

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Connelly

(Address) 117 N Pine St

15- FEB 21 1924

Robert P. Harrison, M. D.

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (Duration) ..... yrs. Don't know

CONTRIBUTORY (Secondary) Don't know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

2-21 1924 (Address) 117 N. Pine St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk

DATE OF BURIAL, 2-23 1924

20-UNDERTAKER, James Bryan & Son

ADDRESS 1000 Paca St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84061

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 3717 Edmondson Ave; St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Louise Hencher

(a) Residence No. 3717 Edmondson Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) September 21/1861

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Hencher

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Louise Goldsmith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs. Eliz Loewer

(Address) 3717 Edmondson Ave

15- Robert F. Harrison,

Filed ....., 19.. Burial Permit Clerk Registrar.

B 2 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) February 21/24

17- I HEREBY CERTIFY, That I attended deceased from February 1, 1924 to February 21, 1924

that I last saw her alive on February 20, 1924,

and that death occurred, on the date stated above, at 11:35 9 m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Chas A Cannon, M. D.

, 19 (Address) 4704 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	2-23, 1924

20-UNDERTAKER.	ADDRESS
Thos. F. A. & G. Ryder	1000 Arlington Ave

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 84062

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1317 Int. Royal Ave ST.: 11 WARD)

2-FULL NAME Catherine Hoey.

(a) RESIDENCE. No 1317 Int. Royal Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 12th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Patrick Hoey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Miss Hoey (Sister)
(Address) 1317 Int. Royal Ave

15 [illegible] Robert P. Harrison, Registrar

FEB 21 1924

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 13 1924, to Feby 19 1924, that I last saw her alive on " " 1924, and that death occurred, on the date stated above, at 1.30 A. m. Feby 20/24

The CAUSE OF DEATH* was as follows:

Valvular Heart Dis

Acute (duration) Some yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank A Morgan, M. D.

, 19 (Address) 1500 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral.	2/22 1924

20 UNDERTAKER John A. Moran ADDRESS 3000 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 34063

CERTIFICATE OF DEATH.

100-001 ✓
D 34063

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST.; 70 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Fannie Downes.

(Residence in Baltimore: No. Home for the aged of the M.E Church St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, or MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, July (Month) 29 (Day), 1857 (Year)

7-AGE, 66 yrs. 6 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): H.O

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas Tuttle

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Harrison

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Lindsay

(Address) 400 N. Fulton Ave

15- FEB 27 1924 Robert F. Harrison, Registrar.
Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Febry (Month) 20 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febry 14 1924, to Febry 20 1924, that I saw her alive on Febry 20 1924, and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Oedema Pulmonary.

(Duration) 1 yrs. 1 mos. 3 ds.

(Signed) George C. Shannon M. D.

2/21, 1924 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet	Feb 27, 1924
20-UNDERTAKER George J Smith	ADDRESS 153 Hollins St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84064

CERTIFICATE OF DEATH.

179 D 84064

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Amanda Brown

(Residence in Baltimore: No. Home for the Aged of the M. E. Church St.; 78 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, September (Month) 27 (Day), 1838 (Year)

7-AGE, 85 yrs. 4 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Frederick Co Md

PARENTS.

10-NAME OF FATHER, John Greentree

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER Catherine Dahoff

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cuddy

(Address) 400 N. Fulton Ave

15-

Filed FEB 21 1924 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Febry (Month) 21 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 2 1924, to Febry 21 1924, that I saw her alive on Febry 20. 1924, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

..... Nephritis Chronic

..... (Duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Bronchitis Acute

..... (Duration) ✓ yrs. ✓ mos. 10 ds.

(Signed) George C. Shannon M. D.

2/21, 1924 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Co — DATE OF BURIAL, Feb. 23, 1924

20-UNDERTAKER George J. Smith — ADDRESS 1532 Hollins St.

...ING INK—THIS IS A PERMANENT RECORD
...plied. AGE should be stated EXACTLY. PHYSICIANS should ...e
...y be properly classified. Exact statement of OCCUPATION ...very
...important. See instructions on back of certificate.

D 84065 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84065

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2783 Parkwood ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Malthon

(Residence in Baltimore: No. 818 N. Carroll Mus ave St.; 39 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	White	Married

6-DATE OF BIRTH. June 16th 1884
(Month) (Day) (Year)

7-AGE. 39 yrs. 8 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER. D. Fountain

11-BIRTHPLACE OF FATHER. (State or Country) Caroline Co

12-MAIDEN NAME OF MOTHER. Mary Roberts

13-BIRTHPLACE OF MOTHER. (State or Country) Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm C. Malthon

(Address) 818 N Carroll Mus ave

15- Filed FEB 21 1924 192.... Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John T. Morrison M. D.
(Coroner.)

Feb 21 1924 (Address) 3632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Westminster Md DATE OF BURIAL, Feb 22 1924

20-UNDERTAKER, Wm J Tickner & Son ADDRESS N. Y. Pa.

FEB 21 1924

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DARK

Spec.—1-10-21—M&T—1500 Bks.

D 84066 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84066

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 569 Walnut Alley ST. 17 WARD)

2-FULL NAME Lizzie Adams

(a) RESIDENCE NO. 569 Walnut Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Scott Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Dame Skates

(Address) 569 Walnut St

Filed FEB 21 1924, 19— Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 - 1923. to Feb. 20 1924.

that I last saw her alive on Feb. 19 1924

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 5 mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Health Department

(Signed) Dr GW Kennard M. D.

2-24 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Samuel Ann, DATE OF BURIAL Feb 23, 24

20 UNDERTAKER John H. Tradin ADDRESS 14-3 Wash 34

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 34067

CERTIFICATE OF DEATH.

49 D 84067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edgewood Hosp (Emory) ST., 13 WARD)

2-FULL NAME Morton Hyman

(a) RESIDENCE No. 2425 Linden Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., If of foreign birth? 1 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Copel Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Goldie Margolis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Bess Hyman

(Address) 2425 Linden ave

15 Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 1, 1924, to Feby 21, 1924,

that I last saw him alive on Feby 21, 1924,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

superinduced by Tumor on Brain

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tumor on Brain 10 M

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Exploratory operation

(Signed) E. M. Duncan, M. D.

2/21. 1924 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	2/22 1924
20 UNDERTAKER	ADDRESS 1124 E. Baltimore St
J. Slaimson & Bro	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84068

CERTIFICATE OF DEATH.

101-001 ✓ D 84068

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital 1122 n Mount St. 13 WARD)

2-FULL NAME Mrs Rose Cluster

(a) RESIDENCE NO. 2204 Bryant Ave., ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr. David Cluster

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER deceased —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER — Dushock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hosp. Record
(Address) Colonial Hosp.

15 FEB 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb-17 ..... 1924 ..... to Feb 21 ..... 1924.

that I last saw her alive on Feb. 21 ..... 1924.

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home 2204 Bryant Ave

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) I. P. Robinson, M. D.

2/22 1924 (Address) 1122 n mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — DATE OF BURIAL: 2/22 1924

20 UNDERTAKER: S. Levinson & Bro — ADDRESS 1124 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84069

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

D 84069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1110 Mc Donough St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Henry Ziegler

(a) Residence No... 1110 Mc Donough St., Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Rosa Ziegler

6-DATE OF BIRTH (month, day and year) Dec 4 1859

7-AGE, 64 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Musician

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

1876

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Ziegler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dorothea Ruth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) John Ziegler

(Address) 137 N Potomac

15-

FEB 22 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feby 19-1924

17- I HEREBY CERTIFY, That I attended deceased from February 19, 19.... to Feb 19, 19 24

that I last saw h. alive on Feb 19, 19 24

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Exposure to Cold

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? at 1110 Mc Donough St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas J. Simms M. D.

, 19 (Address) 1625 N Wolfe

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Feby 22 19 24
20-UNDERTAKER. John Ullrich	ADDRESS 2008 Adams

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84070

CERTIFICATE OF DEATH.

100-001 ✓

D 84070

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 E. North Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roland. Edlinger

(Residence in Baltimore: No. 2332 E. North Av Sex M Col. W Single Age 32 yrs., 8 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 5th (Day) 1891. (Year)

7-AGE 32 yrs. 8 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Manager
(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Albert Edlinger

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Minnie Gernand

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Edlinger

(Address) 2332 E. North Av

15-

FEB 22 1924

ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 20th (Month) (Day), 1924. (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 16th 1923, to Feb 18th 1924, that I saw him alive on February 18th 1924, and that death occurred, on the date stated above, at 1230 Am.

The CAUSE OF DEATH* was as follows:

Endocarditis Asthenia

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Grippal

(Duration) ....yrs. 4 mos. ....ds.

(Signed) J. B. Saunders M. D.

Feb 21st, 1924 (Address) 719 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery — DATE OF BURIAL, Feby 23rd, 1924

20-UNDERTAKER George Schilling & Sons — ADDRESS 1126 E. Monument St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(THIS IS A PERMANENT RECORD)

Spec.—1-10-21—M&T—1500 Bks.

D 84071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 ✓

D 84071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3536 Pod St., 13 WARD)

2-FULL NAME Jeremiah Fisher

(a) RESIDENCE No. 3536 Pod St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Savilla Fisher

6 DATE OF BIRTH (month, day, and year): July 20 1831

7 AGE: Years 92 Months 7 Days

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Christian Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mrs M Dyer 3536 Pod St

15 Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): feby 21 19 24

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 19 23. to Feby 21, 19 24.

that I last saw h[illegible] alive on Feby 18, 19 24

and that death occurred, on the date stated above, at 10 a, m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W Westcott, M. D.

Feb 22 19 24 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys ✝ DATE OF BURIAL: Feb 23 19 24

20 UNDERTAKER: A S Marshall ADDRESS: 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

) 84072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 84072

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Saint Agnes Hosp. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Brilliant

(a) Residence No. 1601 E. Pratt St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Esther Brilliant

6-DATE OF BIRTH (month, day and year) Sept 1886

7-AGE. 37 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Isaac Brilliant

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Brucha —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 E Balt St

15-

Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 21/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 6 1923 to Feb 21 1924

that I last saw him alive on Feb 21 1924

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma —

Cachexia —

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/28/23

Was there an autopsy? not

What test confirmed diagnosis? (Operation)

(Signed) M. Alexander Nivey M. D

19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Hebrew Rest	2/27 19 24
20-UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balt St

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 84073

CERTIFICATE OF DEATH.

129 B 84073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Lasky

(a) RESIDENCE NO. 1819 Lindenau ? ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta Lasky

6 DATE OF BIRTH (month, day, and year) 5/ ____

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Baltimore St

15 Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar (duration) Some time Days yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Peters, M. D.
(Coroner.)
2/22, 1924 (Address) 1639 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 1 yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? ?
Former or usual residence 1819 Lindenau Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom Cem	2/22 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Baltimore St

matlon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 D 84074

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Orleans ST., 6 WARD)

2-FULL NAME Emerson Clay Bailey

(a) RESIDENCE NO. 2026 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Bailey

6 DATE OF BIRTH (month, day, and year): September

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Machinist 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Parke Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: California Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Bertha Bailey 2026 Orleans St

15 Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar

17 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1924, to Feb 19, 1924, that I last saw h. alive on Feb 19, 1924, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia with Empyema

* Septicemia

(duration) yrs. - mos. 24 ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos 7 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earl Stengle M. D.

2026 Orleans St (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Feb 23 1924

20 UNDERTAKER: John H. Denny — ADDRESS: 715 Light St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84075

CERTIFICATE OF DEATH.

41 D 84075

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1305 N. Luzerne Ave. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Margaret Brown

(a) Residence No. 1305 N. Luzerne Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	~~Widowed~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William O. Brown

6-DATE OF BIRTH (month, day and year) Nov. 15th 1846

7-AGE.	If LESS than 1 day.
77 yrs. 3 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Hartmann

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Ortt

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant)..Mrs. Emma Chance

(Address)..1305 N. Luzerne Ave.

15- [illegible] 19.. ROBERT R. KRAUTER,

FEB 22 1924 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1924, to Feb 21st, 1924,

that I last saw her alive on Feb 20th, 1924,

and that death occurred, on the date stated above, at 9.42 A.M.

The CAUSE OF DEATH* was as follows:

Gangrene of leg.

(Duration)..yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Sipheumia - Arteriosclerosis Mitral Insufficiency

(Duration)..yrs..mos..ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) L. McClarke, M. D.

, 19 (Address) 1114 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cemetery	Feb 23rd 1924
20-UNDERTAKER.	ADDRESS
Ralph B. Cook	1003 N. Balto St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84076

CERTIFICATE OF DEATH.

181-001 ✓ D 84076

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 569 Harlem Av ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence C. Lowry

(a) RESIDENCE NO. 526 Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alverta Lowry

6 DATE OF BIRTH (month, day, and year) April 14 1880

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
43	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Carroll, Md.
(State or country)

PARENTS

10 NAME OF FATHER Basil S. Lowry

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Alverta Lowry
(Address) 526 Hoffman St.

15 Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, Advanced

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

(Signed) J. J. Newman, M. D.
(Coroner.)

Feb. 21, 192 4 (Address) 2 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Feb 22 192 4

20 UNDERTAKER Howard Hawley ADDRESS Belle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84077

CERTIFICATE OF DEATH.

REGISTERED NO. 154-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Greenmount ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Clinton

(a) RESIDENCE NO. 529 Greenmount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Clinton

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Melody

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant Agnes Clinton

(Address) 529 Greenmount Ave

15 Filed FEB 22 1924 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1924, to Feb 14, 1924, that I last saw h alive on Feb. 14, 1924, and that death occurred, on the date stated above, at 10 50 a. m.

The CAUSE OF DEATH* was as follows:

Foramen Ovale

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Shelley, M. D.

2/8, 1924 (Address) 1230 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. Co

DATE OF BURIAL 2/21 1924

20 UNDERTAKER Samuel H. Mosby

ADDRESS 1228

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1654 84078 — VB 84078

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

2-FULL NAME George Fisher

(a) RESIDENCE NO. 1017 E. Oliver St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
34	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —"— 0"0

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1924, to Feb 18, 1924, that I last saw him alive on Feb 18, 1924, and that death occurred, on the date stated above, at 7 15 A.m.

The CAUSE OF DEATH* was as follows:

Syphilis. Syphilitic aortitis
Aortic insufficiency. Myocardial insufficiency.

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Walter B. Stewart, M. D.

2/19, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	2/22 1924
20 UNDERTAKER	ADDRESS
Samuel Hawley	2 Biddle

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84079

CERTIFICATE OF DEATH.

23 D 84079

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Forrest ST., 10 WARD)

2-FULL NAME Jane Ann Moran

(a) RESIDENCE No. 1023 Forrest ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick J. Moran

6 DATE OF BIRTH (month, day, and year): Jan 23-1862

7 AGE: Years 63 Months — Days 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Patrick J. Moran

(Address) 1023 Forrest St

15 FEB 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924, to Feb 19, 1924, that I last saw her alive on Feb 19, 1924 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Encephalitis Lethargica (duration) 3 ags mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Kenton M. D.

(Address) 704 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edmond Cem DATE OF BURIAL 2/22 1924

20 UNDERTAKER: Ide Wheatfield ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-2/–E.B.R.S.–400 Bks.

D 84080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 84080

1-PLACE OF DEATH

City of BALTIMORE: (No. 2909 Parkwood Ave St. 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Louise Rock

(a) Residence No. 2909 Parkwood Ave St. ..... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Rock

6-DATE OF BIRTH (month, day and year) Nov 7 1845

7-AGE 78 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs W F Rock

(Address) 2909 Parkwood Ave

15- FEB 22 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1923 to Feb 20 1924

that I last saw h.. alive on Feb 20 1924

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Immediate

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism Angina Pectoris

1-2 mos

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 2-28 hrs

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Barrett C. Carlin M. D

, 19 (Address) 1404 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Feb 22 1924

20-UNDERTAKER: W. J. Tucker Sons — ADDRESS: Norfolk Va

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Ingram, 2109 N. Charles St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84081

CERTIFICATE OF DEATH.

90 D 84081

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2203 North Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria L Garver

(a) Residence No. 2203 North Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Daniel A Garver

6-DATE OF BIRTH (month, day and year) March 15. 1844

7-AGE, 79 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cat Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Abram Stuffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Stener

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Donald A Garver

(Address) 2203 North Charles St

15- FEB 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 14, 1924, to July 20, 1924, that I last saw her alive on July 20, 1924, and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) Unknown mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical Signs

(Signed) W H Ingram M. D.

, 19 (Address) 2139 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL, Feb 23, 1924

20-UNDERTAKER Wm Cook — ADDRESS 502 E Fort Ave.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84082

CERTIFICATE OF DEATH.

44 D 84082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 454 Whitridge ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Bokel

(a) RESIDENCE NO. 454 Whitridge ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Adolph A Bokel

6 DATE OF BIRTH (month, day, and year) June 24, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 197

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md

PARENTS

10 NAME OF FATHER Henry Bakel

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Alice A Kelso X

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) md

14 Informant Joseph Bakel
(Address) 454 Whitridge ave

Filed FEB 22 1924, 19.. ROBERT M. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1922 to Feb 20, 1924.

that I last saw her alive on Feb 19, 1924

and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 3 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of liver

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation & Autopsy

(Signed) John A Faulk M. D.

2/25, 1924 (Address) 3522 Greenmount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feb 23, 1924

20 UNDERTAKER — ADDRESS

Wm. Cook Sons E. Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

Harry Dibble – 1224 Sw

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84083

CERTIFICATE OF DEATH

Brooklyn 101-001 Hanover

D 84083

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 442 Patapsco Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Fields

(a) Residence No. 442 Patapsco Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma V. Fields

6-DATE OF BIRTH (month, day and year) June 14 86?

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman 162

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Woman's Hospital

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, ? Fields

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-(Informant) Emma V. Fields

(Address) 442 Patapsco Ave

15-

FEB 22 1924

ROBERT P. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 21st – 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 20th 1924 to Feb. 21st 1924

that I last saw him alive on Feb. 21st 1924

and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted? If not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Kleibel M.D.

2/22 1924 (Address) 1224 Hanover St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore DATE OF BURIAL. Feb. 25 1924

20-UNDERTAKER. Wm Cook ADDRESS 506 North Ave

IMPORTANT STATEMENT OF PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924-56 ✓ 84084 — X 113 D 84084

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH John Hopkins Hosp.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Glenwood Lowe

(a) RESIDENCE No. 102 Powellton Ave. Yardowne, Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 15 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Aug 5 1922

7 AGE — Years: 1 — Months: 6 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —"—
(c) Name of employer: —"—

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Percy Lowe

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.J.

12 MAIDEN NAME OF MOTHER: Louis Vanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Records
(Address): John Hopkins Hosp

15 FEB 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Feb 21, 1924, that I last saw him alive on Feb 21, 1924, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:
Endemnutrition

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Diarrhea (not dysentery)
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. R. Dugg, M. D.
, 19 ..... John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pulu Pa — DATE OF BURIAL: 2/25 1924

20 UNDERTAKER: Jno J Gibbons — ADDRESS: 1100 N Broadway

PLEASE WRITE WITH PENCIL OR WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84085

CERTIFICATE OF DEATH.

90 D 84085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Light St., 23 WARD)

2-FULL NAME Francis P. Listerer

(a) RESIDENCE No. 1124 Light St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 18, 1915

7 AGE Years 8 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Listerer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emma Sites

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs. Francis Listerer 1124 Light St.

15 Filed FEB 22 1924 ROBERT R. KRAUTER Deputy Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20th, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20th, 1924, to Feb. 20th, 1924, that I last saw him alive on Feb. 19th, 1924, and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis followed by myocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) — yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination & X-ray

(Signed) Stanley Kleiber M. D.

2/21, 1924 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/22 1924

20 UNDERTAKER

ADDRESS 138 Eutaw St.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D 84086

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28th WARD)

2-FULL NAME Charles G. Jones

(a) RESIDENCE No. Mount Hope Retreat ST., 28th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~Ow~~	42	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER J. Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) W. Rine (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Gambrill

13 BIRTHPLACE OF MOTHER (city or town) Howard (State or country) Md.

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md.

15 FEB 22 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1918, to Feb. 21, 1924, that I last saw living alive on Feb 20, 1924, and that death occurred, on the date stated above, at 4-20 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy.

Abt (duration) 20 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Epileptic Psychosis.

Abt (duration) 20 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Feby 22 1924

20 UNDERTAKER John O. Mitchell ADDRESS 1251 W. Fayette St.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1924 D 84087

CERTIFICATE OF DEATH.

100-001 ✓ D 84087

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME T. Theodore Taylor

(a) RESIDENCE No. 1408 Mosher St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Sept. 19, 192[illegible]

7 AGE: Years — Months 5 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Preston Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Louise Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Record

(Address): John Hopkins Hosp

15 Filed FEB 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924 to Feb 21, 1924.

that I last saw him alive on Feb 21, 1924,

and that death occurred, on the date stated above, at 10.9. m.

The CAUSE OF DEATH* was as follows:

Pneumonia. (primary Bronchs)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Mixed, M. D.

2-22-1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon — DATE OF BURIAL: Feb 22 1924

20 UNDERTAKER: Sam'l W. Chase Sons — ADDRESS: 1400 Mosher

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84088

CERTIFICATE OF DEATH.

84088

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624-E. 30th St. ST.; 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick G. Weaver

(a) RESIDENCE. No. 624-E. 30th St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Weaver

6 DATE OF BIRTH (month, day, and year) 10/29/1833

7 AGE: Years 90 Months 3 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chambersburg Pa.

PARENTS

10 NAME OF FATHER John R. Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant John L. Weaver

(Address) 624-E. 30th St

FEB 23 1924 19 Robert T. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 10. 1924, to Feb. 20. 1924, that I last saw him alive on Feb. 20. 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) old age

(duration) years yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm. H. Blade, M. D.

, 19 (Address) 1014 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestnut Grove Maryville Pa.

DATE OF BURIAL: 2/23/24

20 UNDERTAKER: J. W. Jenkins

ADDRESS: 1633 E. North Ave.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84089

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 100-001 84089

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: NO..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Hullegan

(a) RESIDENCE NO. Hagerstown Md ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.. min.
		8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George B Hullegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Ella J Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John Hopkins Hosp.

15 FEB 23 1924

16 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 13 - 1923 to Feb 21 - 1924.

that I last saw her alive on Feb 21 - 1924.

and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Yes -

(Signed) Chas. H Burrell M. D.

, 19 (Address) - Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	Feb 22 1924
20 UNDERTAKER	ADDRESS
Joseph Ahern	221 Bway

Burial Permit Clerk

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84090 D 84090

CERTIFICATE OF DEATH.

1294

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N. Charles ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Summerfield Baldwin

(a) RESIDENCE NO. 1006 N Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, ~~or divorced~~
~~WIFE of~~ HUSBAND of Maria Sewell

6 DATE OF BIRTH (month, day, and year) Sept 16 - 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	91	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton Manf.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Wm H Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A Co. Md

12 MAIDEN NAME OF MOTHER Maria Woodward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant Summerfield Baldwin Jr.
(Address) 1006 N. Charles St.

15 FILED FEB 23 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

B 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1924

17

I HEREBY CERTIFY, That I attended deceased from January 10th, 1923, to Feb 21st, 1924, that I last saw him alive on 3 pm, Feb 21st 1924, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Cardiac Complications (Senility)

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia,

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical history

(Signed) Wilmer Barton, M. D.

, 19 (Address) 1. W. Cor. Calvert & Centre Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL 2-23-1924

20 UNDERTAKER Henry W. Jenkins & Sons Co — ADDRESS McCulloh cor Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WRITE WITH FOUNTAIN PEN OR BLACK INK—THIS IS A PERMANENT RECORD. Every item of information

Spec.—1-10-21—M&T—1500 Bl.

D 84091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84091

94-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Suffolk St ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Worthington Johnson

(a) RESIDENCE NO. 302 Suffolk St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If ~~married, widowed, or divorced~~ (or) WIFE of Late Albert A Johnson

6 DATE OF BIRTH (month, day, and year) July 19th 1849

7 AGE: Years 74; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore to Md.

PARENTS

10 NAME OF FATHER: John P Dashiell

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Sarah W. Gunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore to Md.

14 Informant: Mrs. Worthington

(Address) 302 Suffolk St

15 B 2 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 21st 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 16 , 1924 to Feby 21st , 1924 .

that I last saw h e alive on Feby 20th , 1924 .

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Broncitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Advanced age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mucosal rales

(Signed) John T Pennington, M. D.

, 19 (Address) 1826 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Feb 22 1924
20 UNDERTAKER	ADDRESS
J W Jenkins & Son Co	Orchard & Collins

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 34092

CERTIFICATE OF DEATH.

1460 84092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 S High St ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Columbia Melpsio

(a) RESIDENCE NO. 238 S High St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Melpsio

6 DATE OF BIRTH (month, day, and year) June 11 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Marraccio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Tartaglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Tartaglia

(Address) 1520 E Eighth St

15 Filed ....., 19..... Robert F. Haffigan Registrar

B 23 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to Feb 20, 1924, that I last saw h.. alive on Feb 20, 1924, and that death occurred, on the date stated above, at 8. 45 m.

The CAUSE OF DEATH* was as follows:

Pernicious Influenza

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	Feb 25 1924
20 UNDERTAKER	ADDRESS
Wendel Hoppe & Son	37 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84093

CERTIFICATE OF DEATH.

D 84093

100 - 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Hasselberger Court ST. 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Wilson. (C)

(a) RESIDENCE No 1118 Hasselberger Court, WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Widow.

5a If married, widowed, or divorced
(or) WIFE of John Wilson. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant John Spence. (C)
(Address) 1118 Hasselberger Court.

Dec 23 1924, 192 Robert T. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 21, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia. Primary.
Acute dilatation of the Heart.

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Feb, 22, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ct — DATE OF BURIAL Feb 25 1924

20 UNDERTAKER J. K. Brown & Son — ADDRESS W. Monto.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84094

CERTIFICATE OF DEATH.

10-001 D 84094

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 Eselen ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Williams

(a) RESIDENCE. No. 742 Eselen ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ mins.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Richard Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nettie Williams

(Address) 742 Eselen St

15 Filed FEB 23 1924, 19 Robert F. Harris Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Feb 20, 1924, that I last saw h— alive on Feb 20, 1924, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles T. Fossum, M. D.

(Address) 711 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	Feb 24 1924
20 UNDERTAKER	ADDRESS
J. H. Brown & Son	1018 Mont

FEB 23 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1272 Riverside Ave. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Tagmyer

(a) Residence No. 1272 Riverside Ave. St., 24th Ward W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry S. Tagmyer

6-DATE OF BIRTH (month, day and year) Feb. 22 1890

7-AGE.	If LESS than 1 day,
34 yrs. 0 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....Housework.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Monroe County. Ohio

PARENTS.

10-NAME OF FATHER. James J. Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ohio

12-MAIDEN NAME OF MOTHER. Elizabeth Augus

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ohio

14-

(Informant) Harry S. Tagmyer

(Address) 1272 Riverside Ave.

15-

FEB 23 1924

Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 16, 1924 to Feb 22, 1924 that I last saw her alive on Feb 22, 1924 and that death occurred, on the date stated above, at 4.54 p. m.

The CAUSE OF DEATH* was as follows:

Puerperal hemorrhage

(Duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Placenta Praevia

(Duration) 0 yrs. 7 mos. 0 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis?.....

(Signed) Henryt Buettner M. D

Feb 22, 1924 (Address) 1243 William St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Paden City W. Va.	2/25, 1924
20-UNDERTAKER.	**ADDRESS**
S. Tew McCully	130 E Fort

IMPORTANT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84096

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Georgetown Road ST., 25 WARD)

2-FULL NAME Madelena Horn

(a) RESIDENCE NO. 2303 Georgetown Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick C. Horn

6 DATE OF BIRTH (month, day, and year) July 22-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (37)

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Born at Sea

PARENTS

10 NAME OF FATHER Valetine Hail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Leutebrel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick C. Horn

(Address) 2303 Georgetown Road

15 Filed ....., 19.... Robert F. Harrison Registrar

R 2 31024

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923, to Feb 24, 1924, that I last saw h[illegible] alive on Feb 21, 1924, and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. — mos — da.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

(Address) 222 Abgate Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Feb 25 1924

20 UNDERTAKER George L Schwartz — ADDRESS 401 Fredk Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84097

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1830 W. Saratoga St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aquilla Jackson Pumphrey

(a) Residence No. 1830 W. Saratoga St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ann O. 1851

6-DATE OF BIRTH (month, day and year)

7-AGE. 72 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 61

(b) General nature of Industry, business, or establishment in which employed (or employer) Veterinarian

(c) Name of employer Self City

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. George F. Pumphrey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). U.S.A. Md.

12-MAIDEN NAME OF MOTHER Maryann Lyons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14-

(Informant) Martha Virginia Pumphrey

(Address) 1830 W. Saratoga St.

15-

Filed ..... 192.....

Robert F. McSherry, Registrar.

Burial Permit Issued

FEB 23 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 21-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922 to Feb 21, 1924

that I last saw h. alive on Feb 21, 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Throat (Larynx)

(Duration) yrs. 5 mos. 2 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Love M. D

, 19 (Address) 836 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Cemetery

DATE OF BURIAL. 2-25-1924

20-UNDERTAKER. W. Turner & Son

ADDRESS 1 Penna Ave

Instructions to Physicians and Undertakers. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

D 84098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84098

CERTIFICATE OF DEATH.

162

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maternity - Franklin ST. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Jos Bosman.

(Residence in Baltimore: No. 3902 Fayerdale Ave ~~West Fairmount~~ St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) ——

6-DATE OF BIRTH, 2 - 22, 1924. (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 6 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo. Bosman

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Florura Larrimer

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. F. Bosman

(Address) 3902 Fayerdale Ave

15-

Filed ....., 191.. Robert P. Harris, Registrar.

B 231924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 - 22, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-17-1924, to Feb 22 1924 that I saw h.m alive on dead Feb 22 1924 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

.....

Malena Vera.

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) L. Emmett M. D.

2/22, 1924 (Address) 611 Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Feby 25, 1924

20-UNDERTAKER Wm. J. Hickman & Son

ADDRESS Northern

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 84099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84099

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 McMechen ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Gresham

(a) RESIDENCE NO. 518 McMechen ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rosie Gresham ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
(about)	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Rosie Gresham

(Address) 518 McMechen

Filed ..... 19 ..... Registrar

EB 23 1924

Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Feb 21, 1924, (that I last saw him alive on Feb 21, 1924, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Wickham Finley, M. D.

2/22, 1924 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bowles Bros Ebbet Co va

DATE OF BURIAL Feb 24 1924

20 UNDERTAKER John H Owens

ADDRESS 518 Pa Ave N

Burial Permit Clerk

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

FILE YEAR

Spec.—1-10-21—M&T—1500 Bks.

D 84100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-901 D 84100

1-PLACE OF DEATH John Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Blischke

(a) RESIDENCE NO. 503 S. 16th St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2.	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Louis Blischke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sophie Rode

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records.
(Address): John Hopkins Hosp

15 Filed FEB 23 1924, 19.....
Robert F. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 -, 1924 to Feb 22, 1924.
that I last saw him alive on Feb 22 -, 1924,
and that death occurred, on the date stated above, at 8:50 a. m.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cause Unknown
Malnutrition (duration) ..... yrs. 2 mos. 18 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy
(Signed) Casper Irving, M. D.
, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL 2/23 1924

20 UNDERTAKER: Gorsuch & Gibbler — ADDRESS 1739 Eager

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84101 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84101

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 722 S. Lakewood St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Hopkins

(a) Residence No. 722 S. Lakewood St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie Hopkins

6-DATE OF BIRTH (month, day and year): July 16, 1887

7-AGE: 36 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Pipe-fitter 059

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Standard Oil Co.

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: J. D. Hopkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Mary E. Eyriet

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md

14- (Informant): Harry J. Hopkins

(Address): 722 S. Lakewood

15- Filed ... 192... Robert P. Morrison Registrar.

82 31924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 22. 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1923 to Feb. 22, 1924

that I last saw h[illegible] alive on Feb. 22, 1924

and that death occurred, on the date stated above, at 8.20 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Lyman D. Abbott M. D.

, 19 (Address) 1832 N. Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL, Feb 25, 1924

20-UNDERTAKER: Zinkler + Zinkler — ADDRESS 1739 E. Eager St.

Burial Permit Clerk.

IMPORTANT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84102

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2940 Eager Place ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Fuetzke

(a) RESIDENCE NO. 2940 Eager Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 16-1888

7 AGE: 36 Years | Months 3 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sleeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Fred Baumschmidt

886

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Frederick Fuetzke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frederick Fuetzke

(Address): 2340 Eager St City

15 Filed B 23 1924, 19.....

Robert F. Heffron, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-20 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-16, 1924, to 2-20, 1924.

that I last saw her alive on 2-20, 1924

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

La Grippe

Pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) J. Fred Rumpf M. D.

, 19 (Address) 500 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County

DATE OF BURIAL: Feb 23 1924

20 UNDERTAKER: Wm C. Miller

ADDRESS: 2334 Jeffries

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84103

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84103

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 N. Castle St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Winter

(a) Residence No. 2138 McElderry St., Ward.....

(Usual place of abode) (If non-residents give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 18-1923

7-AGE. yrs. 6 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, George Winter

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Dorothy Gebhardt

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14-

(Informant) George Winter

(Address) 502 N. Castle St.

15-

FEB 23 1924

Filed Robert F. Harrison, Registrar.

Burial Permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 21/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 15, 19 24, to Feb 21, 19 24,

that I last saw him alive on Feb 20, 19 24,

and that death occurred, on the date stated above, at 2.30 A m

The CAUSE OF DEATH* was as follows:

Bronco-Pneumonia

(Duration) yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Lemmon M. D.

2/25, 1924 (Address) 718 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, Feb 23 1924

20-UNDERTAKER. Jas E. Miller

ADDRESS 2334 Jefferson St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Every item of information required EXACTLY. PHYSICIANS should state CAUSE OF DEATH AGE should be stated

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 East ST. 5 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Miller

(a) RESIDENCE. NO. 150 East ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John H. Miller

6 DATE OF BIRTH (month, day, and year): July 4, 1862

7 AGE — Years: 61 — Months: 7 — Days: 16 — If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Landmaid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto md.

PARENTS

10 NAME OF FATHER: Joshua Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Elenora Forman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgetown Md

14 Informant (Address): Frances Brown 150 East St.

15 Filed ... 1924 Robert L. Harrison, Registrar

B 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1924

17 I HEREBY CERTIFY, That I attended deceased from ... 1924 to Feb 20, 1924

that I last saw her alive on Feb 20, 1924

and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Chronic Rheumatism

(duration) One yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Link M. D.

(Address) Balto Md 1 2 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	2/24 1924
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1620 E. Fred'k St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 84105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3711 Greenmount Ave ..... St., ... 9 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ..... Francis Wright .....

(a) Residence No. ..... 3711 Greenmount Ave ..... St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6-DATE OF BIRTH (month, day and year) Sept 4/1902

7-AGE.	If LESS than 1 day.
21 yrs. 5 mos. 17 ds.	hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Balto.. Md.

PARENTS.

10-NAME OF FATHER. M.L.Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Laura V. Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Delaware

14- (Informant) ..... Mrs. Laura V. Wright .....

(Address) ..... 3711 Greenmount Ave .....

15-

Filed ..... Registrar.

FEB 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 21/24

17- I HEREBY CERTIFY, That I attended deceased from ..... 1912 ..... to ..... Feb 21/24 ..... 19.....

that I last saw her alive on ..... Jan 18/24 ..... 19.....,

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Paresis- Epilepsy for 19 Yrs.

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 1914

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) ..... M. D

Feb 22/24 (Address) 508 , North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parkwood Cemetery	Feb. 26, 1924

20-UNDERTAKER. Richard F. Linley ADDRESS 1108 Eutaw Place

Instructions: Every item of information must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. Supplied.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84106

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1828 W Lexington St St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John K. Spear

(a) Residence No. 1828 W Lexington St St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lillian E. Spear

6-DATE OF BIRTH (month, day and year) Oct 26/1861

7-AGE. 62 yrs. 3 mos. 26 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Meat salesman

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Anne Arundel Co Md

PARENTS.

10-NAME OF FATHER, John T Spear

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Anne Arundel Co Md

12-MAIDEN NAME OF MOTHER, Jennie Connor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant). Lillian E. Spear

(Address). 1828 W Lexington St

15- Filed ..... 192 Robert P. Harrison Registrar.

B 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/21/24

17- I HEREBY CERTIFY, That I attended deceased from July 20 1921 to Feb 21 1924 that I last saw h.. alive on Feb 18 1924 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. 7 mns. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical and

(Signed) James H Spear M. D.

2/23, 1924 (Address) 1729 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Feby 25, 1924
20-UNDERTAKER. Harry A Cunnacock	ADDRESS 4204 Ridgewood Ave

Every item must be filled in. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22/100-001 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Hurst

(a) Residence No. 715 W. Pratt St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1872

7-AGE.	If LESS than 1 day,
52 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Louis Hurst

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14-

(Informant) Municipal Hospital Records

(Address).....

15-

Filed FEB 23 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-20-24

17- I HEREBY CERTIFY, That I attended deceased from 2-17, 1924, to 2-20, 19.24

that I last saw h[er] alive on 2-20 19.24

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Drake, M. D

2-23, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cem	2/23 1924

20-UNDERTAKER.	ADDRESS
Alan Easton	916 Penna Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84108

CERTIFICATE OF DEATH.

179 D 84108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 n Bruce ST., 19 WARD)

2-FULL NAME Sophia Cook

(a) RESIDENCE NO. 10 n Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Cook

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE: 35 Years | Months | Days | If LESS than 1 day, hrs. or min.

1889

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work: wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Samuel Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Sophie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Wm. Cook

(Address): 10 Bruce ave

15 [illegible]

EB 23 1924

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-21-1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 2 -, 1924, to Feb-21, 1924,

that I last saw h[illegible] alive on 2-20-, 1924,

and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F M Cardozo, M. D.

2-21-1924 (Address) 824 N Hilliard,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Auburn Cem — DATE OF BURIAL 2-23 1924

20 UNDERTAKER: Wm Cook — ADDRESS 916 Bruce

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mation should be carefully supplied. AGE sh... CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on b...

...NK—THIS IS A PERMANENT RECORD. Ev... ...m of infor- ...GE should be stated EXACTLY. PHYSICIANS should state ...t it may be properly classified. Exact statement of OCCUPA- ...on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 768 N. Hamburg ST. 21 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa. Reinhart

(a) RESIDENCE NO. 768 N Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Robt J. Reinhart

6 DATE OF BIRTH (month, day, and year) DEC 19 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	47	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (at home)

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Lehr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Susanna. Snyder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Robt J. Reinhart

(Address) 768 N. Hamburg ave

15 Filed ..... 19 ..... Robert F. HARRISON, Registrar

~~Burial Permit Clerk.~~

B 2 3 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1924, to Feb. 21, 1924,

that I last saw her alive on Feb. 19, 1924,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests

(Signed) J M Ekleroth M. D.

Feb. 23, 1924 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral. Cem.

DATE OF BURIAL 2-25-1924

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S. Paca

MATRON should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84110

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

2-FULL NAME Samuel Edwards

(a) RESIDENCE No. ? Arlington ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER T. W. B. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Amanda Atwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records (Address) M.T.H. JOHNS HOPKINS HOSPITAL

15 Filed FEB 23 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1924, to Feb. 19, 1924, that I last saw him alive on Feb. 19, 1924, and that death occurred, on the date stated above, at 10.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

2-20-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER

ADDRESS

For Wm. E. WOODALL

FEB 23 1924

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84111

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 D 84111

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Bartlett Ave ST.: 9 WARD)

2-FULL NAME Robert Andrew Pitipaw.

(a) RESIDENCE. No. 700 Bartlett Ave ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 3 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/12/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert A. Pitipaw.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Agnes Sweeny.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Robt. A Pitipaw
(Address) 700 Bartlett ave.

15 Filed ..... 19 Robert P. Harrison, Registrar

B 2 31924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22 1924

17

I HEREBY CERTIFY, That I attended deceased from February 9th, 1924, to February 22nd, 1924, that I last saw him alive on February 22nd, 1924, and that death occurred, on the date stated above, at 6 30 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Not any

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1902 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	2/23rd 1924
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84112

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84112

168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 Calhoun St. 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorathea Moritz

(Residence in Baltimore: No. 412 N Calhoun St, 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: July (Month) 10 (Day) 1863 (Year)

7-AGE: ..... yrs. 60 mos. 7 ds. 11 If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Herman Faber

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Charlotte Beck

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Nordmann

(Address) 1174 Osborne ave Catonsville

15-

Filed ..... 192.. Robert F. Harrison, Registrar.

2 31924 [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb (Month) 21 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Strangulation by Hanging

Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mentally Insane

Cirrhosis (Duration) ..... yrs. 3 mos. ..... ds.

(Signed) James M Rawlins M. D. (Coroner.)

Feb 22 1924 (Address) 707 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery DATE OF BURIAL, Feby 23, 1924

20-UNDERTAKER: John O. Mitchell ADDRESS 120 W Fayette St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 B 84113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1220 W Pratt St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip Knell

(Residence in Baltimore: No. 1220 W Pratt St.; yrs., mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Feb (Month) 22 (Day) 1924 (Year)

7-AGE: ...yrs...mos...ds. If LESS than 1 day, 5 hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balt. City.

PARENTS.

10-NAME OF FATHER: John Knell

11-BIRTHPLACE OF FATHER, (State or Country): Balt. City

12-MAIDEN NAME OF MOTHER: Anna Knell

13-BIRTHPLACE OF MOTHER, (State or Country): Balt City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Knell

(Address) 1220 W Pratt

15- Filed FEB 23 1924, 192... Robert P. Harrison, Registrar.

Entd Ferrell Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 22 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foramen Ovale
Endocarditis

(Duration) ...yrs...mos. 4 hrs

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) James W Fenton M. D. (Coroner.)

Feb 26 1924 (Address) 787 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Peters Cem — DATE OF BURIAL: 2/23 1924

20-UNDERTAKER: Robert Masterson — ADDRESS: Calhoun Hollins sts

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

16988 84114

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-08 84114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barrett P. Patterson

(a) RESIDENCE No. 1321 Madison Ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Feb 5, 1874

7 AGE: Years 50 | Months — | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Messenger

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Reynolds Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 2 3 1924 , 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924 to Feb 25, 1924

that I last saw him alive on Feb 21, 1924

and that death occurred, on the date stated above, at 9 40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Type I)

(duration) yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gaithersburg Md — DATE OF BURIAL: Feb 24 1924

20 UNDERTAKER: Joseph Ahern — ADDRESS: 221 B Way

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84115

CERTIFICATE OF DEATH.

179

D 84115

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2012 Mc Elderry ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Wobbs

(a) RESIDENCE. No 2012 Mc Elderry ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Finnegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Catherine Forsyth
(Address) 2012 Mc Elderry St

18 3 23 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to Feb. 22, 1924
that I last saw him alive on Feb. 21, 1924
and that death occurred, on the date stated above, at 2:15 P. m.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration
(Cardio-sclerosis)
(duration) X yrs. mos. ds.

CONTRIBUTORY (Secondary) chronic nephritis, old age arterio-sclerosis
(duration) X yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Bartus T. Baggett, M. D.

, 19 (Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Feby 25 1924
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager St

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to give information that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84116

CERTIFICATE OF DEATH.

164 D 84116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Central Ave ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Tragesser

(a) RESIDENCE NO. 1113 N. Central Ave ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. — mos. — ds. How long in U. S., if of foreign birth? 74 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Jacob Tragesser

6 DATE OF BIRTH (month, day, and year): Oct. 19 1834

7 AGE: Years 89 Months 4 Days 2 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Carl Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Chas. F. Jewett

(Address) 1113 N. Central Ave

15 Feb 23 1924 Robert P. Harrison Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 24 to Feb 21 24

that I last saw h alive on Feb 21 24

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Jewett M. D.

Feb. 24 1924 (Address) 928 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL Feb. 25 1924

20 UNDERTAKER: Henry Hoeck Son ADDRESS 1301 Eutaw

B 23 1924

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONSULTATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84117

CERTIFICATE OF DEATH.

31 D 84117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3156 Cedar Ave 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Rinehart

(a) RESIDENCE NO. 3156 Cedar Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose E Rinehart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles Hunkle

(Address) 3156 Cedar Ave

15 Filed ....., 19.... Albert S. Harrison, Registrar

B 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Feb 22, 1924, that I last saw h.is alive on Feb 22, 1924, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(duration) ... yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. J Davies, M. D.

2-23 1924 (Address) 800 N 33 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Poplar Balto Co	Feb 25 1924
20 UNDERTAKER GRENOWETH & SON,	ADDRESS
2617 CHESTNUT AVE.	

IMPORTANT SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 84118 (×2) B 84118

JOHNS HOPKINS HOSPITAL.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Oberle

(a) RESIDENCE No. 908 E. 21 st St. Sparrows Pt. Md

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or towo and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 29 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	X	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Oberle

11 BIRTHPLACE OF FATHER (city or towo) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kearney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

FEB 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924, to Feb 22, 1924.

that I last saw him alive on Feb 22, 1924.

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, epidemic cerebro-spinal

acute Primary Pneumonia

Septicaemia

(duration) 0 yrs. 5 mos. 22 ds.

CONTRIBUTORY (Secondary) Meningitis, pneumococcus

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Sparrows Point

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacterial Cultures

(Signed) Chas. R. Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Feb 25th 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 405 N. Wolfe St.

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 84119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84119

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 E Woodland Ave ST., 27 WARD)

2-FULL NAME Amelia Fuldtke

(a) RESIDENCE NO. 32 E Woodland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of August. Fuldtke

6 DATE OF BIRTH (month, day, and year) Dec 24 1849

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Ferdenand Fuldtke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emelie Gust.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna G. Steinlauder

(Address) 3022 Wellbrook Ave

15 Filed FEB 24 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1924, to Feb 22, 1924, that I last saw h.e alive on Feb 22, 1924, and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Partial Paralysis)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis & Pulmonary Oedema (duration) yrs. (Latter) mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C.S. Tenor, M. D.

2-23-1924 (Address) 5716 Parkington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn New York — DATE OF BURIAL 2-24th 1924

20 UNDERTAKER Mrs Chas. A. J. Rohde — ADDRESS 600 N Arlington Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84120

CERTIFICATE OF DEATH.

90 D 84120

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 N. Bruce ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Owen Campbell

(a) RESIDENCE NO. 39 N. Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Campbell

6 DATE OF BIRTH (month, day, and year) dec 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Gambrill

(Address) 39 N Bruce St

15 Filed FEB 24 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 1923 to Feb 21 1924.

that I last saw him alive on 2-20-24 19

and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis, Pulmonary

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Turnbull, M. D.

2-23 1924 (Address) 624 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 24 1924
20 UNDERTAKER Binns & Rylands	ADDRESS 114 W Lafayette

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84121

D 84121

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5114 Wayne Ave. St. Howard Park Ward) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Herbert S.Leland,

(a) Residence No. 5114 Wayne Ave, St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary H.Leland

6-DATE OF BIRTH (month, day and year) Jan.28.1838

7-AGE.	If LESS than 1 day.
86 yrs. — mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Mass.

PARENTS.

10-NAME OF FATHER, Moses Leland,

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mass.

12-MAIDEN NAME OF MOTHER, Maneriva Spring,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Mass.

14- (Informant) Harry S. Leland

(Address) 5114 Wayne Ave.

15- Filed FEB 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb, 22.1924

17- I HEREBY CERTIFY, That I attended deceased from 2-11 19 24 to July 22 19 24

that I last saw h. alive on July 22 19 24

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

.....(Duration).....yrs.....mos. 11 ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis?.....

(Signed) Chas F. Stansbury M. D.

, 19 (Address) 7 Main St Hayson 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem.	Feb.25.1924 19
20-UNDERTAKER, Geo W Little	ADDRESS [illegible]

In plain terms, so that it may be properly classified. instructions on back of certificate.

Be EXACTLY. PHYSICIANS should state CAUSE OF DEATH Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 B 84122

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 Stiles Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Laureta V. Barkman

(a) Residence No. 721 Stiles Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Barkman

6-DATE OF BIRTH (month, day and year) July 16, 1851

7-AGE, 72 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Portsmouth (State or Country), Va.

PARENTS.

10-NAME OF FATHER. Nathan Whitehead

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Va

12-MAIDEN NAME OF MOTHER. Martha A. White

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Va.

14- (Informant). Lola V. Barkman

(Address). 721 Stiles Ave

15- Filed FEB 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 23. 1924.

17- I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to Feb 23, 1924, that I last saw h. alive on Feb 22, 1924, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(Duration) 2 yrs. — mos. 7 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) [illegible] M. D.

Feb 25, 1924 (Address) 3002 Fairmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western FEB 25 1924, 19....

20-UNDERTAKER. Robert S. Little

ADDRESS 2700 EDMONDSON AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84123

D 84123

CERTIFICATE OF DEATH.

REGISTERED NO. 135

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1122 N Mount ST., 15 WARD)

2-FULL NAME Mr. Samuel Wylie

(a) RESIDENCE NO. 2303 Harrison Ave, ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., if of foreign birth? 75 yrs. — mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or ~~divorced~~
HUSBAND of
(or) ~~WIFE~~ of Mary B Wylie

6 DATE OF BIRTH (month, day, and year) Jan 17 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	84	1	5	

8 OCCUPATION OF DECEASED 886

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Pork Packer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland -

PARENTS

10 NAME OF FATHER John Wylie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Riller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mame Wylie
(Address) 2303 Harrison Ave

15 Filed FEB 24 1924, 19.. Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 19 24

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1923, to Feb 22, 1924

that I last saw him alive on Feb 22, 1924

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) .... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hypertrophy with Chronic Prostatic relaxation

(duration) ½ yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical tests

(Signed) A. B. Rytina M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park — DATE OF BURIAL Feb 25 19 24

20 UNDERTAKER John B Spence — ADDRESS 1325 N Caroline St

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84124 ✓ X 179 D 84124

CERTIFICATE OF DEATH.

D 84124

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3043 St Paul St. St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ella Sophia Irwin

(Residence in Baltimore: No. 3043 St Paul St. St.; [illegible] hrs. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, aug 17 (Month) (Day), 1849 (Year)

7-AGE, 74 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Truman S. Shipton

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Sophia S. Bilger

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C A Markle

(Address) 3043 St Paul

15 FEB 24 1924 Filed....., 191.....

ROBERT R. KRAUTER, Registrar of Burial Permits

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 13 1924, to Feb 23 1924, that I saw her alive on Feb 22 1924, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis Hemiplegia

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

(Signed) Howard Hagaman M. D.

Feb 23, 1924 (Address) 2604 Garrison Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Penna

19-PLACE OF BURIAL OR REMOVAL. Clearfield Pa

DATE OF BURIAL, Feby 24, 191 4

20-UNDERTAKER Silas O. Stitzell

ADDRESS 120 N Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84125

D 84125

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 1429 Bolton St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie F. Wilmer

(a) Residence No. 1429 Bolton St., Ward.....

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John H. Wilmer

6-DATE OF BIRTH (month, day and year) June 9 1837

7-AGE. 86 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Centreville Md

PARENTS.

10-NAME OF FATHER. Joseph H. Nicholson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Ann Cox Emory

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Sallie E. Wilmer

(Address) 1429 Bolton St

15- Dated FEB 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 23—1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 20th 1924 to Feb 22 1924, that I last saw h. alive on Feb. 22 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(probably Carcinoma of Stomach)

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable carcinoma of Stomach

(Duration) Indefinite yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood count

(Signed) J. Thos. B. E. Deegan M. D

19 (Address) 904 N Charles st

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Centreville Md	Feby 25 1924
UNDERTAKER.	ADDRESS.
John A Mitchell	1201 W Fayette St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Cause stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Annie Scott

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84126

CERTIFICATE OF DEATH.

101-001 ✓

D 84126

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Bethel ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Scott

(a) RESIDENCE. No. 616 Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 23 mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis Scott

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 46; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Mabeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Maryland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sadie Campbell

(Address) 512 S Eden St

15 Filed . 19

FEB 24 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Feb 22, 1924, that I last saw her alive on Feb 22, 1924, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows: (a) Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): As above

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) C. H. Flowers, M. D.

(Address) 712 S Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: Feb 24 1924

20 UNDERTAKER: John W Henderson

ADDRESS 1601 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84127

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1702 N Duncan St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie Hoffman

(a) Residence No. 1702 N Duncan St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Hoffman

6-DATE OF BIRTH (month, day and year) 1838

7-AGE. 86 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Solomon David Hoffman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Shona Chomo

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Baltimore St

FEB 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/23/24

17- I HEREBY CERTIFY, That I attended deceased from Sept, 1923, to Feb 23, 1924

that I last saw h... alive on..... 19.....

and that death occurred, on the date stated above, at 5:50 P.m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Infectious arthritis

(Duration) ...yrs. 5 mos. ...ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Herman Seidel M. D.

19 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Memory Park	2-24 19 24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Balto St

Filled in by Undertaker only. Supplies should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84128

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

D 84128

1-PLACE OF DEATH Hebrew Home for Incurables — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2102 E. Baltimore ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Kuff

(Residence in Baltimore: No. 107 S. High St.; 20 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: June 14th (Month) (Day), 1861 (Year)

7-AGE: 62 yrs. 8 mos. 9 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Hebrew Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: unknown.

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Kuff

(Address) 22 S. Broadway

15-

Filed FEB 24 1924 191 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February 23 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February, 1924, to February, 1924, that I saw him alive on February 22nd 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY) Acute dilatation of Heart

(Duration) yrs. mos. one ds.

(Signed) Samuel Silverstein M. D.

Feb. 24 1924 [Address] 22 South Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Sinai Cem. Co. — DATE OF BURIAL: Feb. 24 1924

20-UNDERTAKER: Jack Lewis — ADDRESS: 1821 E. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

16963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84129

CERTIFICATE OF DEATH.

101 D 84129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 5 WARD)

2-FULL NAME Eugene Frank Rosi

(a) RESIDENCE NO. 1127 E. Fayette St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 22 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Frank Rosi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Barnes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed FEB 24 1924 ROBERT R. VRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Feb 23, 1924, that I last saw h— alive on Feb 23, 1924, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar (unresolved)

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1127 E. Fayette St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo. F. Bragg M. D.

2/23 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	9/24 1924

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Baltimore St

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Nick Myulas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84130

CERTIFICATE OF DEATH.

X 31

D 84130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp. ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nick Moulas

(a) RESIDENCE No. U.S. Marine Hospital #1 ST., — WARD

(Usual place of abode) Baltimore, Md.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 32 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: S/S City of St. Joseph

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Self

(Address)

15 FEB 24 1924 Registrar

ROBERT R. KRAUTH, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 23 1924.

17

I HEREBY CERTIFY, That I attended deceased from December 29 1923. to February 23 1924.

that I last saw him alive on February 23 1924.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis.

(duration) 1 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, Physical Exam

(Signed) W. F. Fuller, M. D.

19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL 2/24 1924

20 UNDERTAKER: Sol Kinsey & Bro. — ADDRESS 1127 E Baltimore

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84131

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 B 84131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1042 Baldwin St. St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ethel Marie Hartlove

(a) Residence No. 1042 Baldwin St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 11-1922

7-AGE, 1 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry Hartlove

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Hortense Small

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Harry Hartlove

(Address) 1042 Baldwin St.

15- Filed FEB 24 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 22 19 24, to Feb 23 19 24, that I last saw h. alive on Feb 23 19 24, and that death occurred, on the date stated above, at 12-30 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Grip

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Stephen A Dunn, M. D.

, 19 (Address) 1109 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, Feb 26 19 24

20-UNDERTAKER, Wm Cook — ADDRESS 502 E Lexington

In plain terms, so that it may be properly classified. Instructions on back of certificates.

Filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84132

CERTIFICATE OF DEATH.

185 D 84132

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Martinet

(a) Residence No. 1712 Barkley Stret St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Morris J. Martinet

6-DATE OF BIRTH (month, day and year) March 20, 1839

7-AGE. 84 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Hubbard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Rebecca Mahonney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Geo W Martinet

(Address) Belvedere Hotel

15-

Filed ..... 192 ROBERT R. KRAUTER Registrar.

FEB 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/22/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 3 1923 to Feb. 22 1924 that I last saw h.. alive on Feb. 22 1924 and that death occurred, on the date stated above, at 1-45 A. m. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Fractured Hip

(Duration) yrs. 2½ mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Fulton, M. D

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore cem.	Feb. 25, 1924
20-UNDERTAKER,	ADDRESS
Lemcook	505 E March

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84133

CERTIFICATE OF DEATH.

90 D 84133

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S. Linwood Ave ST., 1 WARD)

2-FULL NAME James W. Murphy

(a) RESIDENCE No. 815 S. Linwood Ave ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) J. B. Marsden.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary J. Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Thomas J. Murphy (Brother)

(Address) 2915 Fait Ave.

15 Filed FEB 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923, to Feb 21, 1924, that I last saw h[illegible] alive on Feb 21, 1924 and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? None

(Signed) W. L. Burke, M. D.

(Address) 1004 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Feb 25 1924

20 UNDERTAKER Lilly and Zeiler. — ADDRESS 403 S. Wolfe St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84134

CERTIFICATE OF DEATH.

179 D 84134

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 S Collington ST.; 1 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen E Clark

(Residence in Baltimore: No. 729 S Collington Av St.; 73 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug. (Month) 27 (Day), 1850 (Year)

7-AGE, 73 yrs. 5 mos. 25 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joshua Turner.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Rebecca Scoggins

13-BIRTHPLACE OF MOTHER (State or Country), Balto - Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary King (Sister)

(Address) 1535 N. Milton Ave

15-

Filed FEB 24 1924, 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 21 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1924, to Feb 21 1924, that I saw h.r alive on Feb 21 1924, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. 1 mos. ds.

(Signed) Charles F Block M. D.

Feb 24, 1924 (Address) 20 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Pk Cem. DATE OF BURIAL, Feb. 27th, 1924

20-UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

IF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84135

CERTIFICATE OF DEATH.

1929 D 84135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Druid Hill Ave ST., 4 WARD)

2-FULL NAME Mariah Blackwell

(a) RESIDENCE NO. 1407 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Blackwell

6 DATE OF BIRTH (month, day, and year) Oct. 30-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	70	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10 NAME OF FATHER John Fitzzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Keziah Beatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant (Address) 1407 Druid Hill Ave. Dave Alexander

15 Filed FEB 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 1924 to Feb. 21 1924

that I last saw her alive on Feb. 20 1924

and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 3 mos. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 4 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John H. Thompkins M. D.

(Address) 1014 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb 24 1924

20 UNDERTAKER Jas. M. Johnson

ADDRESS 1309 Druid Hill

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be given as correctly as possible. Be sure that it is plain and legible. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ASK FOR COPY

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84136

CERTIFICATE OF DEATH.

74-001 D 84136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Louis Bentley

(a) RESIDENCE No. 1014 Linden Av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bentley

6 DATE OF BIRTH (month, day, and year) May 5 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59 yrs.	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer General

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Bentley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Martha F. Butler (Address) 1014 Linden Ave.

15 Filed FEB 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Hemmeter, M. D. (Coroner.)

Feb. 22, 1924 (Address) 2 W Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... rs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Feb. 25 1924

20 UNDERTAKER Wm. M. Johnson — ADDRESS 1509 Druid Hill Av

PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D84137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D84137

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3419 O'Donnell St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Stower

(a) Residence No. 3419 O'Donnell St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov 22-1923

7-AGE.	If LESS than 1 day,
....yrs. 3 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Wm. Stower

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md

12-MAIDEN NAME OF MOTHER, Johanna R. Limpert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Co. Md

14-(Informant) Wm. Stower

(Address) 3419 O'Donnell St

FEB 25 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 24 1924

17- I HEREBY CERTIFY, That I attended deceased from 2/21, 19.24, to 2/24, 19.24, that I last saw h.. alive on 2/24/24 19....., and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Carroll M. D.

7/25 1924 (Address) 633-S-Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Stemers Run	Feb 26 1924
20-UNDERTAKER.	ADDRESS
Sirkler & Sirkler	1739 Eager St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH should state

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84138

CERTIFICATE OF DEATH.

D 84138

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Harrington

(a) Residence No. 35 Race St., Scranton St., Pa Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Mrs Nora Harrington

6-DATE OF BIRTH (month, day and year) 1874

About 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Garage Owner

(b) General nature of industry, business, or establishment in which employed (or employer) Self 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Pa.

PARENTS.

10-NAME OF FATHER Thomas Harrington

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12-MAIDEN NAME OF MOTHER Mary Lloyd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14-Informant Mrs Nora Harrington

(Address) 35 Race St Scranton Pa

15-FILED FEB 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 23 24

17-I HEREBY CERTIFY, That I attended deceased from Feb 19 1924 to Feb 23 1924

that I last saw him alive on Feb 23 1924

and that death occurred, on the date stated above, at 6 23 P. m.

The CAUSE OF DEATH* was as follows:

Embolism Coronary Thrombosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Jaw + Tongue (Duration) yrs. ? mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/22/24

Was there an autopsy? No

What test confirmed diagnosis? Lab Phys Dgs

(Signed) H. H. Harper M. D

(Address) St. Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Scranton Pa DATE OF BURIAL. Feb 27 1924

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N Balto St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

84139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-08 B 84139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Ashland Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Baer

(a) RESIDENCE. NO. 1906 ashland ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced
HUSBAND of Adolph Baer
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Charles Arnold

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Kaiser

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant
(Address)

Filed FEB 24 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 24

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h.....alive on ....., 19.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? .....Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity	Feb 25 1924

20 UNDERTAKER K. C. Wiedefeld ADDRESS 914 Gwynn

DIRECTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84140

CERTIFICATE OF DEATH.

D 84140

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Forrest ST., 10 WARD)

2-FULL NAME Mary Irene Shanahan

(a) RESIDENCE NO. 1016 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. J. Shanahan

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jos McKee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ann McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Thos. J. Shanahan 1016 Forrest St.

15 Filed FEB 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-22-1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 13, 1924, to Feby 21, 1924, that I last saw h[illegible] alive on Feby 21, 1924, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis (Parenchymatous)

(duration) ... yrs. ? mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Bornstein, M. D.

19 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St John's Long Green Md	Feb 25 1924
20 UNDERTAKER	**ADDRESS**
H. C. Windefeld	914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84141 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 84141

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2902 Overland ave St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Alice L. Myers

(a) Residence No. 2902 Overland St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Divorced

5a-If ~~married~~, ~~widowed~~, or divorced ~~HUSBAND of~~ WIFE of Arthur J. Myers

6-DATE OF BIRTH (month, day and year) Nov. 26. 1874

7-AGE, 49 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at her home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Carroll Co Md.

PARENTS.

10-NAME OF FATHER: Reinhart Hoffnagle

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Europe

12-MAIDEN NAME OF MOTHER: Martha Franke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Carroll Co Md

14-
(Informant): Mrs Jno Bittner
(Address): 2902 Overland ave.

15-
Filed FEB 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Feb 23, 1924, that I last saw h.r. alive on Feb 23, 1924 and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation
General Sclerosis
Cancerosa

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

Feb 24, 1924 (Address) 4 N Harford ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem. DATE OF BURIAL, Feb 26, 1924

20-UNDERTAKER: Margaret L. Flynn ADDRESS 1422 Light St

In plain terms, so that it may be properly classified. instructions on back of certificates. ...ED EXACTLY. PHYSICIANS should state CAUSE OF DEATH ...fied. Exact statement of OCCUPATION is very important. See

Spec– 12-23-21– E.B.R.S.—400 Eks.

D 84142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 254 Oakley St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pepper Knight

(a) Residence No. 254 Oakley St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Benjamin F. Knight

6-DATE OF BIRTH (month, day and year) Jan-28-1849

7-AGE, 75 yrs. 0 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo H. Pepper

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown.

12-MAIDEN NAME OF MOTHER, Christina M. Cromwell

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs. M. L. Knight

(Address) 254 Oakley Ave.

FEB 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 23rd 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 17th 1924, to Feb. 22nd 1924

that I last saw her alive on Feb. 22nd 1924

and that death occurred, on the date stated above, at 6.0 m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 15 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Erysipelas & Age

(Duration) yrs. 1 mos. 14 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Donna A. Waldrop M. D

, 19 (Address) 210 East Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount	2/25, 1924
20-UNDERTAKER.	ADDRESS
W. J. Tichnor & Son	North Ave

In plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

84143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 B 84143

1-PLACE OF DEATH

City of BALTIMORE. (No. 902 S Paca St., 21 Ward) Registered No.....

2-FULL NAME August W. Schedt (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 902 S Paca St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine F Schedt

6-DATE OF BIRTH (month, day and year) May 13 1853

7-AGE. 70 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Baetjer & Howard

(c) Name of employer Baltimore

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS

10-NAME OF FATHER, Jacob Schedt

11-BIRTHPLACE OF FATHER (city or town) Alsace Lorraine (State or Country), France

12-MAIDEN NAME OF MOTHER, Elise Volkmann

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country)

14- (Informant) Miss Julia E Schedt

(Address) 902 S. Paca St

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

FEB 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 9th 1924 to Feb 23rd 1924

that I last saw him alive on Feb 22nd 1924

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and Chronic aortic incompetency

(Duration) — yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) General Anasarca

(Duration) — yrs. — mos. 14 ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M D

2/24, 1924 (Address) 1224 Hanover St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, Feb. 192 4

20-UNDERTAKER. Wm J Tucker & Sons ADDRESS North & Pa

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84144

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1004 Wilcox St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Johanna Fitzgerald

(a) Residence No. 1004 Wilcox St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Delgan Fitzgerald

6-DATE OF BIRTH (month, day and year) 2/14/1863

7-AGE, 61 yrs. 0 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cook at [illegible]

(b) General nature of Industry, business, or establishment in which employed (or employer) John School

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Doody

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Sister Mrs Mary [illegible]

(Address) 1004 Wilcox St

15- FEB 24 1924 ROBERT R. KRAUTE Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924 to Feb 22, 1924

that I last saw h[illegible] alive on Feb 22, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

a Chronic Endocarditis

Contributory Myocardial degeneration

Uncertain (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. W. Simmons M. D.

2/23, 1924 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Bonnie Brae Cem. | DATE OF BURIAL, Feb. 25, 1924

20-UNDERTAKER, Elmer W. Cookelin | ADDRESS 924 E Eager St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D-84145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84145

CERTIFICATE OF DEATH.

Registered No. C 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 519 N. Lombard st St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James C. Ward Jr.

(Residence in Baltimore: No. 519 N. Lombard st St.; yrs., ~~mos.~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1..... (Year)

7-AGE: 22 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Book~~

9-BIRTHPLACE, (State or Country): Tenn

PARENTS:

10-NAME OF FATHER: James C Ward

11-BIRTHPLACE OF FATHER, (State or Country): Kentuckey

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER, (State or Country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse A McCormick

(Address) 919 G St NW Washington DC

15- Filed FEB 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 23 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, au-~~ ~~topsy or in~~quiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H. K. Fowler M. D. (Coroner.)

2-24 1924 (Address) 117 W. Saratoga

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Clarksville Tenn — DATE OF BURIAL: Feb. 27. 1924

20-UNDERTAKER: W M Routson — ADDRESS: 223 E Pt Portsmouth

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84146

CERTIFICATE OF DEATH.

38 D 84146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 2 28th WARD)

2-FULL NAME Henry Miller

(a) RESIDENCE NO. Mount Hope Retreat ST., 28th WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: of Mrs Miller

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Watching (?)

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): (?) Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (?) Germany

14 Informant: Hospital Records
(Address)

15 Filed FEB 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1923, to Feb 21st, 1924, that I last saw h[e] alive on Oct Feb 20th, 1924, and that death occurred, on the date stated above, at abt 11 A. m.

The CAUSE OF DEATH* was as follows:

Paresis (Lunatic)
(Suddenly cardiac Paralysis.)

(duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary): Paretic Psychosis

Abt (duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

Feb 21st, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Feb 25 1924

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W Lombard

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84147. HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 84147

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Madison Av ST.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Harrison

(a) RESIDENCE. No. 1014 Madison Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 31-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

087

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Francis Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John G. Taylor

(Address) 614 Madison Ave

FEB 25 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23d 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 22nd, 1924, to Feb 23d, 1924, that I last saw h alive on Feb 23d, 1924, and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute Dilatation.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis. Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sign & Symptoms

(Signed) J. A. Bloland, M. D.

Feb 25th, 1924 (Address) 40 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Feb 26/24

20 UNDERTAKER Chas. E. Franck ADDRESS 807 Madison ave.

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84148

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

58-09 D 84148

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 507 Rose Hill Terrace St.; 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William T. Conley

(Residence in Baltimore: No. 507 Rose Hill Terrace St.; 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 9th, 1852 (Month) (Day) (Year)

7 AGE: 71 yrs. 11 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired merchant
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Joseph Conley

11 BIRTHPLACE OF FATHER (State or country): Pa

12 MAIDEN NAME OF MOTHER: Caroline —

13 BIRTHPLACE OF MOTHER (State or country): Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sallie A Pennycuff

(Address) 507 Rose Hill Terrace

15 FEB 25 1924 ROBERT R. KRAUTER Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 24, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924 to Feb 24 1924, that I saw h— alive on Feb. 21, 1924, and that death occurred, on the date stated above, at 1. P. m.
The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

Ab. 2 or 3 yrs

(Duration) yrs. mos. ds

Contributory (SECONDARY) —

(Duration) yrs. mos. ds.

(Signed) H. G. Prentiss M. D.

Feb. 24, 1924 (Address) 634 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence Pa

19 PLACE OF BURIAL OR REMOVAL: Mount Olivet DATE OF BURIAL: Feb 25th, 1924

20 UNDERTAKER: F. B. Keppert ADDRESS: 2256 Fred'k Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 84149

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 20 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Lancaster

(a) Residence No. 2320 Frederick Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Oct 28-1918

6-DATE OF BIRTH (month, day and year)

7-AGE. 17 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundry Wk

(b) General nature of Industry, business, or establishment in which employed (or employer) Up to Date

(c) Name of employer Laundry

9-BIRTHPLACE (city or town) (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER, Wm Lancaster Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER, Katie Hoffman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md

14-Informant Wm Lancaster

(Address) 2320 Frederick Ave

15-Filed FEB 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 22-1924

17-I HEREBY CERTIFY, That I attended deceased from Jan. 16 1924 to Feb. 22 1924

that I last saw him alive on Feb. 22 1924

and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Staphlococcus Septicaemia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Osteomyelitis

(Duration) yrs. mos. 40 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/18/24

Was there an autopsy? no Date of 1/24/24

What test confirmed diagnosis?

(Signed) H V Harper M. D

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery DATE OF BURIAL, Feb 26 19 24

20-UNDERTAKER. F. B. Hilpert ADDRESS 2236 Fred'k Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. DEATH; CAUSE OF

Spec. [illegible]—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84150

90 D 84150

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 12 WARD)

2-FULL NAME Rev. Thomas H. Jamison

(a) RESIDENCE No. 2545 Reisterstown Rd. ST., Calvert St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. [illegible] mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Theresa A. Jamison

6 DATE OF BIRTH (month, day, and year): Feb 9th 1855

7 AGE: Years 70 Months 3 Days 13 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 066

(b) General nature of industry, business, or establishment which employed or employs:

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Smith Providence

PARENTS

10 NAME OF FATHER: Isaac F. Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina.

12 MAIDEN NAME OF MOTHER: Theresa A. Hemelright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Mamie H. Jamison (Address): 2545 Reisterstown Rd

15 Filed [illegible] 19 [illegible] ROBERT R. KRAUTER Registrar

FEB 25 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1924 to Feb 22 1924 that I last saw h— alive on Feb 22 1924 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Myocard. Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cler. Valvular Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Was an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schumann M. D.

(Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 25 1924

20 UNDERTAKER: H B Hupfeld

ADDRESS: 2256 Frederick ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84151 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 84151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Charles Swikert

(a) RESIDENCE NO. 26 Pearl St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 25, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	46	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER John Swikert

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Young

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Joseph W. Swikert
(Address) 26 Pearl St

FEB 25 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1924, to Feb 22, 1924 that I last saw him alive on Feb 22, 1924 and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A A Sussman, M. D.

2 22, 1924 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 25 1924

20 UNDERTAKER Mr & Mrs. J.W. Teufel & Son — ADDRESS 801 W. Fayette

CAUSE OF DEATH should be stated EXACTLY. Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84152

CERTIFICATE OF DEATH.

117 ✓ D 84152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 15 ~~16~~ WARD)

2-FULL NAME Lou Moody

(a) RESIDENCE NO. 3115 Walbrook ST., ~~Our~~ WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 75 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Moody

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lou Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs J T Simms

(Address): 320 W. Fulton ave.

15 Filed [illegible] ROBERT R. KRAUTER, Registrar

FEB 25 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/22/1924

17

I HEREBY CERTIFY, That I attended deceased from 2/20, 1924, to 2/22, 1924, that I last saw he alive on 2/22/24, 1924, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Perforated appendix with Generalized Peritonitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis, Toxemia

Circulatory Failure (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2/20/24

Was there an autopsy? No

What test confirmed diagnosis? Operative Findings

(Signed) R. T. Plyer, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Feb 25 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light

CAUSE OF DEATH should be stated EXACTLY. Every item of information is very important. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Emma E. Myers.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84153

129 D 84153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 McHenry ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Myers

(a) RESIDENCE No. 1425 McHenry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of William B. Myers

6 DATE OF BIRTH (month, day, and year) Jan 15 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	65	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Wm. Booker

(Address) 1213 Eutaw Pl

15 FEB 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23. 1924.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1 1923. to Feb. 23 1924

that I last saw her alive on Feb. 22. 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urine etc.

(Signed) J. Thos. Worton, M. D.

2/23/24 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National	Feb 25 19
20 UNDERTAKER Wm. Fields	ADDRESS 1310 W. Lombard

CAUSE OF DEATH should be stated EXACTLY. Every item of information is very important. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84154

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1902 Orleans St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Born

(a) Residence No. 1902 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Laura Born

6-DATE OF BIRTH (month, day and year) Sept 4/68

7-AGE. 65 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Store 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Keeper

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Henry Born

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ger.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ger.

14- (Informant) Mrs Chas Hager

(Address) 1902 Orleans St.

15- FEB 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/22/24

17- I HEREBY CERTIFY, That I attended deceased from May 14 1923 to Feb 22 1924 that I last saw him alive on Feb 20 1924 and that death occurred, on the date stated above, at 4 P. m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D

, 19 (Address) 1927 Belmont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, M.R. Carmel — DATE OF BURIAL, 2/25, 1924

20-UNDERTAKER, Philip Herwig — ADDRESS 2016 Orleans St

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 159-002

City of BALTIMORE: (No. 1701 Carswell St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Everett Lafont

(a) Residence No. 1701 Carswell St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 23 1924

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 17 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Wesley Crockett

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country),

12-MAIDEN NAME OF MOTHER Florence Holland

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country),

14- (Informant) Wesley Crockett

(Address) 1701 Carswell St.

15- FEB 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 23, 1924, to Feby 23, 1924

that I last saw her alive on Feb. 23, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Congenital heart

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Horwitz, M. D.

2/24, 1924 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet DATE OF BURIAL, Feb. 25, 1924

20-UNDERTAKER, H. M. Cook 702 E. H. Ave ADDRESS

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84156

CERTIFICATE OF DEATH.

154-002

154 D 84156

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 704 E 35th ST.; 9 WARD)

2-FULL NAME John Raymond Weber

(a) RESIDENCE. NO. 704 E 35th ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-12-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John H Weber

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Stella Swoke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant William H Weber
(Address) 704 E 35th st

15 Filed ..... 19 ..... (Signed) ROBERT R. KRAUTER, Registrar
FEB 25 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-12 1924, to 2-23 1924,
that I last saw him alive on 2-23 1924,
and that death occurred, on the date stated above, at 8 30 P. m.
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis
Acute & Chronic

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Clinical Signs

(Signed) Denis Brailey, M. D.

, 19 (Address) 1506 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 25 1924
20 UNDERTAKER	ADDRESS
Josiah Lefer & Son	W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84157

CERTIFICATE OF DEATH.

X 3 D 84157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hosp. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nick Lazarevich

(a) RESIDENCE NO. U.S. Marine Hosp. ST., WARD Non Resident

(Usual place of abode) Baltimore, Md (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman.

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer Tug Tamaqua

9 BIRTHPLACE (city or town) (State or country) Servia.

PARENTS

10 NAME OF FATHER Un Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un Known

12 MAIDEN NAME OF MOTHER Un Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un Known

14 Informant Self

(Address)

FEB 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1924

17

I HEREBY CERTIFY, That I attended deceased from December 8 1923, to February 24 1924.

that I last saw him alive on February 24, 24.

and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows

Chronic Pulmonary Tuberculosis

(duration) yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Un known.

Did an operation precede death? no Date of —

Was there an autopsy? no Physical + Laboratory

What test confirmed diagnosis?

(Signed) M. F. Fox, M. D.

, 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	2/25 1924
20 UNDERTAKER	ADDRESS 1127
Ad Lipsen + Bro	E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84158 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 71-001

D 84158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., | | WARD)

2-FULL NAME Reva Cohen

(a) RESIDENCE NO. 15 E. Center ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. ds. How long in U. S., if of foreign birth? 2 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	6	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Sol Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Minnie Groff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Paris

14 Informant S. L. Groff (Address) 5 E Center st

15 FEB 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1924, to Feb. 27, 1924, that I last saw her alive on Feb. 24, 1924, and that death occurred, on the date stated above, at 2.05 p. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) yrs. mos 5-10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Rufus C. Weber M. D.

2/26 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run DATE OF BURIAL 2/25/1924

20 UNDERTAKER Sol Leimson ADDRESS 1127 E. Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84159

CERTIFICATE OF DEATH.

74-001 D 84159

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Monument & Rutland Hebrew Hospital ST., 7 WARD)

2-FULL NAME Mrs. Fannie Ruley

(a) RESIDENCE NO. 614 N. Lakewood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced (or) WIFE of: Late John F Ruley

6 DATE OF BIRTH (month, day, and year): Nov 30-1870

7 AGE: 54 Years, 3 Months, 23 Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Kellenbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Brady Howes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Catherine Ruley 614 N Lakewood ave

15 Filed FEB 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 17, 1924, to Feb 23, 1924.

that I last saw her alive on Feb 23, 1924,

and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (right sided Hemiplegia

(duration) 3½ hours

CONTRIBUTORY (Secondary) Hypertension & Chronic Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Isidore I. Jay, M. D.

Feb. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb 26 1924

20 UNDERTAKER: Jay E. Butler — ADDRESS: 2334 Pennsylvania ave

CAUSE OF DEATH should be stated EXACTLY. Every item of information is required. AGE should be stated in plain terms, so that it may be properly classified. PHYSICIANS should state it is very important. Exact statement of OCCUPATION on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84160

CERTIFICATE OF DEATH.

14-001

D 84160

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Fifth ST., 76 WARD)

2-FULL NAME Christina Rabenstein

(a) RESIDENCE NO. 120 S. Fifth ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widowed

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Charles Rabenstein

6 DATE OF BIRTH (month, day, and year) Feb 3-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	-	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Diffenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bruno Lori

(Address) 249 S. 5th St.

15 Filed FEB 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23. 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. , 1923 , to Feb 23 , 1924 ,

that I last saw h~~er~~ alive on Feb. 23 , 1924 ,

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & B. P.

(Signed) Frank A. Glantz, M. D.

Feb 24, 1924 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb 26 1924
20 UNDERTAKER Wm C. Miller	ADDRESS 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 84161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84161

CERTIFICATE OF DEATH.

100-09

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N Greene st ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmela Geppi

(Residence in Baltimore: No. 422 N. Greene st St.; ....yrs. 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Jan 23d, 1924
(Month) (Day) (Year)

7-AGE, ✓ yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Rosario Geppi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosalia Geppi

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Geppi

(Address) 422 N Greene st

15-

Filed FEB 25 1924, 191.... ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 23d, 1924
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Feb 20 1924, to Feb 23d 1924, that I saw h er alive on Feb 23d 1924, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Chas Testa M. D.

....., 191... (Address) 210 Park st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, 2/25/1924

20-UNDERTAKER Jno J Pett — ADDRESS 735 Hudson

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 84162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 101-00 D 84162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Belvidere ST.: 12 WARD)

2-FULL NAME. Robert Stanton

(a) RESIDENCE. No. 1417 Belvidere ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1904

7 AGE — Years: 19 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Frank Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Minnie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Cora Stanton (Address) 1417 Belvedere St

FEB 25 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1924 to Feb. 22, 1924 that I last saw him alive on Feb 22, 1924 and that death occurred, on the date stated above, at 11:0 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. N. Hatcher, M. D.

(Address) 1225 Penn Ave, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb. 25 1924

20 UNDERTAKER: J. A. Farrell — ADDRESS: 2319 Linden Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84163 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-001 D 84163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Fleishman

(a) RESIDENCE NO. 128 S. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unkn mos. ds. How long in U. S., If of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE: 81 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital

15 Filed FEB 25 1924 19.. Registrar. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/24

17 I HEREBY CERTIFY, That I attended deceased from November 14, 1923 to February 23 1924, that I last saw her alive on Feb. 22 1924, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Senile Psychosis

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Term. Bronchopneum. (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? B. V. H.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Dorsett M. D.

2/16 19.. (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 1924

20 UNDERTAKER: Rundell Dysle & Son — ADDRESS: 378 Penn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 84164

D 84164

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 902 Fawn ST.: B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Barbarino

(a) RESIDENCE. No. 902 Fawn ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sabastiano Barbarino

6 DATE OF BIRTH (month, day, and year) December 28 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Barbarino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Gerdana Barbarino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Selestana Barbarino (Address) 902 Fawn

15 Filed FEB 25 1924 19.. ROBERT R. KRAMER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to Feb 23, 1924, that I last saw h.. alive on Feb 23, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

Feb 26, 1924 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb-26 1924
20 UNDERTAKER	ADDRESS
Kindell Dyer & Son	378 Penn

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 84165

D 84165

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1710 Harlem Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Melvin Lettau

(a) Residence No. 1710 Harlem Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 5, 1923

7-AGE. yrs. 9 mos. 19 ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Christian Lettau

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Elsie Hornsby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Calvert Co Md

14- (Informant) Mr. Christian Lettau

(Address) 1710 Harlem Ave

15-

Filed 192

FEB 25 1924

ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 19 24 to Feb. 24 19 24

that I last saw him alive on Feb. 24, 19 24

and that death occurred, on the date stated above, at 2 45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Weinberg M. D

Feb. 24 19 24 (Address) 724 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Feb. 25 1924
20-UNDERTAKER. Jas Joerdens Son	ADDRESS 2178 Pace

I hereby certify that the above is a true copy of the original certificate filed in the Health Department of Baltimore City.

Witness my hand and seal of the Health Department this 25th day of February 1924

ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Causes of death which may be properly classified, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

D 84166

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 ✓ D 84166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp: ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown.

(a) RESIDENCE NO. 3809 Clinton Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 0d0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jas. C. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Nellie McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hosp. Record

(Address)

15 FEB 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 19 24, to Feb 24, 19 24, that I last saw h alive on Feb 24, 19 24, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Intrauterine Asphyxia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Transverse Presentation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. V. Segerbecker, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine de Grace Md.	2-25 1924

20 UNDERTAKER	ADDRESS
Est B Hanke	115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84167

CERTIFICATE OF DEATH.

90 D 84167.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4710 Fendall Ave. WARD 28)

2-FULL NAME Sarah Augusta Thomas

(a) RESIDENCE No. 4710 Fendall Ave., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis D Thomas

6 DATE OF BIRTH (month, day, and year) April 2 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
81	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Kent Co.

PARENTS

10 NAME OF FATHER James F Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Tilden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Trinby F. Thomas

(Address) 3408 Morton ave Howard Park

15 Filed FEB 25 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to Feb 24, 1924.

that I last saw him alive on Feb 24, 1924,

and that death occurred, on the date stated above, at 9:40 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Weakness

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) A. C. Smith, M. D.

19 24 (Address) 4909 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W Fairview Cem Stumbaugh Kent Co. Md. DATE OF BURIAL: Feb 26 1924

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 84168

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S. Paca ST.: 22 WARD)

2-FULL NAME Peter Masilunas

(a) RESIDENCE. No. 508 S. Paca ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? 12 yrs. 1 mos 24 ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Alex. Mikolajunas

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Alexander Mikalaiunas (Address) 508 S. Paca St.

15 FEB 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to Feb. 24, 1924, that I last saw him alive on Feb. 24, 1924, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	2/26 1924
20 UNDERTAKER Charles B. Kuchnacky	ADDRESS 637 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84169

CERTIFICATE OF DEATH.

D 84169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hosp. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Clark Whitacre.

(a) RESIDENCE NO. H A Kelly Hosp ST., WARD Whitacre, Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Anna Whitacre.

6 DATE OF BIRTH (month, day, and year) Sept 12th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Whitacre, Virginia

PARENTS

10 NAME OF FATHER Mr. Rumrod Whitacre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick County, Va.

12 MAIDEN NAME OF MOTHER Anne Mauzy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr. H. S. Whitacre

(Address) Martinsburg, W. Va. (Son)

15 FEB 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1924, to Feb. 24, 1924, that I last saw him alive on Feb. 24, 1924, and that death occurred, on the date stated above, at 10-20 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency following operation for benign hypertrophy of prostate. (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Whitacre, Va

Did an operation precede death? Yes Date of Feb. 22, 1924

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Robert E. Fricke, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winchester Va	Feb 26th 19 24
20 UNDERTAKER James B Hynes	ADDRESS 1324 Eutaw St

CAUSE OF DEATH should be stated EXACTLY. Every item of information is very important. See instructions on back of certificates. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-

S. A. E.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84170

CERTIFICATE OF DEATH.

101-001 D 84170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 N. Montford Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Barton

(a) RESIDENCE NO. 1210 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER John Small Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co. Pa.

12 MAIDEN NAME OF MOTHER Rebecca Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Mrs Stephen D Glines

(Address) 206 E 20th St

15 FEB 25 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to Feb 23, 1924

that I last saw her alive on Feb 23, 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D Berry Mc Sherry, M. D.

(Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feb. 26 1924

20 UNDERTAKER Henry Hoeck & Son — ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

COPY

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84171

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 East 31st St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert James McCaddin

(a) Residence No. 415 East 31st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write this word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Lillian McCaddin

6-DATE OF BIRTH (month, day and year) Aug. 14-1863

7-AGE. 60 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Stove Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Washington DC

PARENTS.

10-NAME OF FATHER John F. McCaddin

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Isabella A. Lackey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (Informant) Lillian McCaddin

(Address) 415 E 31st St.

15- 2 Dec. 192 ROBERT H. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 24/1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 16/24, 19..., to Feb 24, 19 24, that I last saw h.i.m. alive on Feb 22, 19 24, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy + Dilated Heart.

2

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

2

1 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) W. J. Costello, M. D.

, 19 (Address) 335 E 31st St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL, Feb 27, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North

PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84172 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84172

CERTIFICATE OF DEATH. X 38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Holmes

(a) RESIDENCE NO. Bay View Asylum ST., WARD Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE: Years 43; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Municipal Hospital Records
(Address)

15 FEB 25 1924 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-6, 1920, to 2-22, 1924, that I last saw her alive on 2-22, 1924, and that death occurred, on the date stated above, at 9-4 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Right Hemiplegia & Aphasia

Syphilis

(duration) 3½ yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Terminal) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Drace, M. D.

2-22, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Feb. 25 1924

20 UNDERTAKER: Mack & Co. Elliott — ADDRESS: 725 Cathedral

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84173

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 S Spring ST., 3 WARD)

2-FULL NAME Geo E Pence

(a) RESIDENCE No. 2321 S Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 80

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Lonnie Cyle

15 Address 2321 S Spring

FEB 25 1924

Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Not certified

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Weber, M. D.
(Coroner.)

2-25, 192 (Address) 1 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Feb. 25th 1924

20 UNDERTAKER Miss R. G. Elliott ADDRESS Pikesville

...at it may be properly classified. PHYSICIANS should state EXACTLY. Exact statement of OCCUPA-
...TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84174

CERTIFICATE OF DEATH.

129

D 84174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3015 Windsor Ave St., 15 WARD)

2-FULL NAME Mrs Amelia Miller

(a) RESIDENCE NO. 3015 Windsor Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Justus Miller

6 DATE OF BIRTH (month, day, and year) Jan 25, 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm. H. Miller

(Address) 3015 Windsor Ave

15 FEB 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25- 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Feb. 25- 1924, that I last saw her alive on Feb 25- 1924, and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. Urinary Exam.

(Signed) Elv Billups, M. D.

19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Feb. 27 1924

20 UNDERTAKER Robert S. Little ADDRESS 2788 Edmondson Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84175 ✓ D 84175

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hold Rennert ST., 4 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. R. Edmonston

(a) RESIDENCE No. 328 N Green ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1919

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
5-5-about			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D. C.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Dr Grant (State or country) Washington D C

14 Informant Wm E. Edmonston
(Address) 1925 19th St NW D C

15 FILED FEB 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid
Cyanide Potassium
and Def (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Mackey, M. D.
(Coroner)
Feb. 23 1924 (Address) 1257 Edward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Born here
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Washington D.C. DATE OF BURIAL 2/25/1924

20 UNDERTAKER E. J. Fanning & Son - 1386 ADDRESS Lafayette

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84176

CERTIFICATE OF DEATH.

74001 V

D 84176

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2946 W. North Ave ST., 15 WARD)

2-FULL NAME James J. Dunn

(a) RESIDENCE NO. 2946 W. North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna S. Dunn

6 DATE OF BIRTH (month, day, and year) Jan 7, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fire Dept. (Retired)
(b) General nature of Industry, business, or establishment in which employed (or employer) Balto City Fire Dept.
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Dunn

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Johanna S. Dunn
(Address) 2946 W. North Ave.

15 Filed ..... 192.... ROBERT R. KRAUTER, Registrar
FEB 25 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner's (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history (duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Feb. 24, 1924 (Address) 2802 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 2/26/1924

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1460 Battery Ave.

THION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

Bradley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84177

CERTIFICATE OF DEATH.

91-002 ✓

D 84177.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Somerset ST., 10 WARD)

2-FULL NAME Andrew J. Bradley

(a) RESIDENCE NO. 1027 S Somerset ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Driscoll

6 DATE OF BIRTH (month, day, and year) Oct 30 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Formerly Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Alexander Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jas Bradley

(Address) 1027 E Somerset St

FEB 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23 1924

17

I HEREBY CERTIFY, That I attended deceased from 2/14, 1924, to 2/23, 1924, that I last saw h alive on 2/23, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Leonard Watts, M. D.

2/24, 1924 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feb. 25, 19 24

20 UNDERTAKER Edmund W. Conklin ADDRESS 924 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

D 84178 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84178

CERTIFICATE OF DEATH. 24 100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Cox.

(a) RESIDENCE NO. 1825 Balt Street. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 5 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Julian Cox.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Barbara Cumm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Hospital Record.
(Address)

FEB 25 1924 ROBERT R. KRAUTH Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/24

17 I HEREBY CERTIFY, That I attended deceased from 12/26/23, 19..., to 2/25/24, 19..., that I last saw h alive on 2/25/24 19... and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Chest Pain
Malnutrition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. W. Holley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 2/26 1924

20 UNDERTAKER L. F. McCully ADDRESS 130 N Front

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84179

CERTIFICATE OF DEATH.

179 D 84179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 5 WARD)

2-FULL NAME Henry Campbell

(a) RESIDENCE NO. 136 N. Front ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	72 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hospital Record
(Address)

15 FEB 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/24

17 I HEREBY CERTIFY, That I attended deceased from 2/23/24 to 2/23/24.

that I last saw h alive on 2/23/24

and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. W. Gilby, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	2/26 1924

20 UNDERTAKER George J. Ruth ADDRESS 1755 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84180

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Webster Young

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 Filed 2 5 1924, 19
Robert P. Harrison,
Registrar
Burial Permit Clerk.
197

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 22 1924

17

I HEREBY CERTIFY, That I attended deceased from 1 - 11, 1923, to 2 - 22, 1924, that I last saw h alive on 2 - 21, 1924, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

(duration) yrs. 14 mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Drane, M. D.

2-23 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 25 1924

20 UNDERTAKER Commissioner of Health.
per Wm. F. WOODALL

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84131

CERTIFICATE OF DEATH.

D 84131

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Chapman

(a) Residence No. 129 Winter Street St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE, 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Maryland.

PARENTS.

10-NAME OF FATHER, John Chapman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Jay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant)

(Address)

15- Filed 1924

Robert F. Harrison, Registrar.

Burial Permit Clerk.

1165

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/21/24

17- I HEREBY CERTIFY, That I attended deceased from February 13 1924 to February 22 1924

that I last saw him alive on February 21 1924

and that death occurred, on the date stated above, at 8-20 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Wm. J. Fulton M. D

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, 19

20-UNDERTAKER,

ADDRESS

Commissioner of Health.

FEB 25 1924

Please write plainly, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3813 Park Heights Ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Zander

(a) Residence No. 3813 Park Heights Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 2/1850

7-AGE. 73 yrs. 8 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, Geo. Zander

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Father Germany

14- (Informant) Father (Address) 3813 Park Heights Ave

15-

Filed Robert F. Harrison, Registrar.

B 2 51924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Dec 24/24

17- I HEREBY CERTIFY, That I attended deceased from ..... 19...., to ..... 19.....

that I last saw h.....alive on ..... 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

a

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19.... (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Hebrew Cem.	2/26/1924
20-UNDERTAKER, David Sondheim	ADDRESS 118 W. Mt. Royal Ave

IMPORTANT—PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16744 D 84183 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 ✓ D 84183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME George Clinton Lewis

(a) RESIDENCE NO. 14 01 Division ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 5-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Louise Lewis

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed 3 25 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 16 - 1924 to Feb 23 1924.

that I last saw him alive on Feb 23 - 1924,

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Meningitis (Pneumococcus)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? St. Vincents Orphan

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. A. Mead, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Wm. Garrett. DATE OF BURIAL Feb 26 1924

20 UNDERTAKER M. Tuckey & Sons ADDRESS 1817 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84184

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1833 Lemmon St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberta Brown

(Residence in Baltimore: No. 1833 Lemmon St.; 19 yrs. 10 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: April 12 1904 (Month) (Day) (Year)

7-AGE: 19 yrs. 10 mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Charles E Grist

11-BIRTHPLACE OF FATHER, (State or Country): Balto City

12-MAIDEN NAME OF MOTHER: Anne M

13-BIRTHPLACE OF MOTHER, (State or Country): Prince Georges Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Grist

(Address) 335 S. Calhoun St

15- Filed 2 5 1924 192 Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 24 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage
(Child was not delivered)

(Duration) ....yrs. ....mos. 3 days

CONTRIBUTORY (Secondary) Placenta Previa

(Duration) about 5 hours

(Signed) James M. Fenton M. D. (Coroner.)

Feb 24 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cemetery DATE OF BURIAL, Feby 27 1924

20-UNDERTAKER, Harry N Arnsdorf ADDRESS 420 N Eutaw St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should be very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84185

CERTIFICATE OF DEATH.

74-09

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ft. Timothy Dee

(a) Residence No. Preston & Valley St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of James Dee

6-DATE OF BIRTH (month, day and year): Unknown

Or AGE: about 85 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Daniel Quinn

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Burns

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-

(Informant): Sister Florence

(Address): Preston & Valley

15-

Robert P. Harrison, Registrar.

2 5 1924 Burial Permit filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feby 23/24

17- I HEREBY CERTIFY, That I attended deceased from No record 19 to 19

that I last saw h alive on Feb 22 19 24

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Feby 23 24. 19 (Signed) K. L. Barnes M. D

(Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem

DATE OF BURIAL: Feb 26 19 24

20-UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Gilmor St

To prevent delay, the following instructions should be carefully observed. Exact statement of OCCUPATION is very important. Cause of death must be properly classified. Space must be filled in only as directed. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84186

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 414 E. Chase ST., 10 WARD)

2-FULL NAME Jennie Storck

(a) RESIDENCE NO. 414 E. Chase ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Storck

6 DATE OF BIRTH (month, day, and year) June 25 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER John Barth

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Bolster

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Geo Storck

(Address) 414 E. Chase St

Filed Feb 25 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1924

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1920, to Feb. 23, 1924, that I last saw h alive on Feb 23, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation heart from over Exertion (duration) yrs. 10 mos. Mitral

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Kenton, M. D.

(Address) 701 Clarell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Feb 26 1924

20 UNDERTAKER H. C. Wildefeld ADDRESS 914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84187.

CERTIFICATE OF DEATH.

74-001 ✓ D 84187

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2603 E Fayette ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Quinn

(a) RESIDENCE No. 2603 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ella E. Quinn

6 DATE OF BIRTH (month, day, and year) Oct 31-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Custodian

(b) General nature of industry, business, or establishment in which employed (or employer) Nash Monument

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER James Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Agnes Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Wm. Quinn 2603 E Fayette St

15 2 5 1924 Robert F. Harrison, ..., 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 11- 1924 to Feb 23 1924

that I last saw h alive on Feb 23 1924

and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Paralysis)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Intercurrent

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Exam.

(Signed) Geo. Luther Blade, M. D.

(Address) 143 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	2/26/24
20 UNDERTAKER	ADDRESS
John A Moran	500 E Balto

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Hupka

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84188

CERTIFICATE OF DEATH.

179

D 84188

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2617 Keyser st. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Hupka

(a) Residence No. 2617 Keyser st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, ~~or Divorced~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph Hupka

6-DATE OF BIRTH (month, day and year) July. 19/843

7-AGE: 80 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany.

PARENTS.

10-NAME OF FATHER: Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Austria.

12-MAIDEN NAME OF MOTHER: Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Slovak.

14-

(Informant): Jacob M. Kaufman

(Address) 2617 Keyser st

15-

Filed ..... 19.....

Registrar.

2 5 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 27 1923 to Feb 23 1924

that I last saw her alive on Feb 23 1924

and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B B Herzog M.D. M. D

2/23, 1924 (Address) 1305 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Holy Redeemer Cemetery.	2/26
20-UNDERTAKER,	**ADDRESS**
Geo. J. Ruth.	1735 Hanford ave.

All questions must be answered so far as the information can be obtained. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84189

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Cor. Myrtle Ave & Gen'l Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Idella A. Sachs.

(a) RESIDENCE No. 934 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 27, 1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52 yrs.	3 mos.	27 days	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Justus Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Geo. Mathes (Address) 934 Harlem Ave.

15 Filed 3 25 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocardial degeneration

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. F. Hennessy, M. D.
(Coroner.)

Feb. 25, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Feb 26 1924

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2173 Bdwy

IMPORTANT—Answer every question if information is obtainable. Omission of any item may cause certificate to be returned for completion. Write plainly with pen and ink. Use no abbreviations. Do not use ditto marks. Be sure that it may be properly classified. Exact statement of OCCUPATIONS should state what is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84190

CERTIFICATE OF DEATH.

74-001 ✓ D 84190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Finnerty

(a) RESIDENCE NO. 1104 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Finnerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash D.C.

14 Informant (Address) Municipal Hospital Records

15 Filed 2 5 1924 Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-26 1923 to 2-23 1924

that I last saw her alive on 2-23 1924,

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Right Hemiplegia (Cerebral Hemorrhage)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude S. Drane, M. D.

(Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Feb. 27 1924

20 UNDERTAKER Margaret G. Lyons

ADDRESS 422 Light St.

CAUSE OF DEATH in plain terms, so that it should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84191

CERTIFICATE OF DEATH.

46 D 84191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Sycamore Ave. St.; 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Hanes

(a) RESIDENCE. No. 1321 Sycamore Ave. St. WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John E Hanes

6 DATE OF BIRTH (month, day, and year) Sept. 12 1879

7 AGE	44 Years	5 Months	11 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nurse work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant John E Hanes

(Address) 1321 Sycamore Ave

FEB 26 1924 ROBERT R. KRAMER, Registrar,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23. 1923 to February 23. 1924, that I last saw her alive on February 17. 1924, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Chronic Epithelioma of uterus following hydatiform mole.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cancerous cachexia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/24/23 & 7/2/23.

Was there an autopsy? no.

What test confirmed diagnosis? Section removed.

(Signed) Edward P. Johnson M. D.

. 19 (Address) 1212 St. Paul St. City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery (Catonsville)	Feb 26 19 24
20 UNDERTAKER Franklin H Leigh	ADDRESS 709 W 33rd St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84192

CERTIFICATE OF DEATH.

D 84192

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Rose Place ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine Goines

(a) RESIDENCE NO. 4 Rose Place ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		2	21 days.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) (Infant) Dr.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Major Goines

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER [redacted] Mary Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Major Goines
(Address) 4 Rose Place

15 FEB 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

(Signed) D. E. Hennessy, M. D.
(Coroner.)

(Address) 2802 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cem

DATE OF BURIAL 2-26 1924

20 UNDERTAKER David Eutow

ADDRESS 916 Fa Ave

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 84193

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 107 Brayton ST.: 11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Frances

(a) RESIDENCE. No. 107 Brayton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Frances

6 DATE OF BIRTH (month, day, and year) March 10, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Keeping House

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Caroline Co Va

PARENTS

10 NAME OF FATHER William Page Catlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Va

12 MAIDEN NAME OF MOTHER Sallie Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co Va

14 Informant Robert Frances

(Address) 107 Brayton St

15 Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to Feb 24, 1924, that I last saw her alive on Feb. 24, 1924, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Abdominal Fistulae - Septicemia

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 1923. Johns Hopkins Hospital

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William J. Wright, M. D.

25, 1924 (Address) 1209 Cresaberan St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	2-26 1924
20 UNDERTAKER	ADDRESS
David Easton	916 Eu ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84194
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

66 D 84194
REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.) 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael F. O'Toole

(a) RESIDENCE. No. 1305 E Biddle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? Expt yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) the late Mary E. O'Toole

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER M. O'Toole

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Mrs. O'Neill.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant Mr. Mrs. J. O'Toole.
(Address) 901 Fairfield Ave Hamilton Md

15 FEB 26 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to Feb 25, 1924, that I last saw h... alive on Feb 24, 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno O'Toole, M. D.

Feb 26, 1924 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
New Cathedral Cemetery Feb. 28 1924

20 UNDERTAKER — ADDRESS
Henry Hoech Son 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84195

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 Woodbrook Ave ST., 13 WARD)

2-FULL NAME Mary E. Lookingbill

(a) RESIDENCE NO. 2569 Woodbrook Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? 26 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ezra V. Lookingbill

6 DATE OF BIRTH (month, day, and year) January 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None wd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Henry Blayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Susana Gogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Ezra V. Lookingbill

(Address) 2569 Woodbrook Ave

15 FEB 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1923, to Feb. 25, 1924, that I last saw her alive on Feb. 21, 1924, and that death occurred, on the date stated above, at 10.40 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 3 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Brights disease (duration) 10 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. Alpert, M. D.

, 19 (Address) 1950 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Silver Run Cem. Carroll Co Md

DATE OF BURIAL Feby 28 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84196

CERTIFICATE OF DEATH.

T 11-001

D 84196

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1711 E 28th ½ (St.) 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessis J. Cullum

(a) RESIDENCE (No.) 1711 E 28th (St.) " (Ward) Harford Co

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Martha Cullum

6 DATE OF BIRTH (month, day, and year): Nov. 10 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Jessie Cullum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Eliza Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: Mrs Martha Cullum (Address) 1711 E 28th St

15 Filed FEB 26 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24. 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1924. to Feb 24, 1924, that I last saw h[illegible] alive on Feb 24, 1924, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Bronchial

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. T. Zimmerman M. D.

2/24 1924 (Address) 2708 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Churchville Harford Co	Feb 27 1924

20 UNDERTAKER: Peter Nicolaus & Co

ADDRESS: Eastern Av

TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84197

CERTIFICATE OF DEATH.

101-001

D 84197.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 E. Weber St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Blackston. (C)

(a) RESIDENCE No 22 E. Weber St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ---- mo. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Married

5a If married, widowed or divorced (or) WIFE of John Blackston. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 60		----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant John Blackston. (C)
(Address) 22 E. Weber St.

15 FEB 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

Feb, 25, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Feb-26 1924
20 UNDERTAKER	ADDRESS
J. R. Brown & Son	108 W. Monroe

Instructions on back of certificate. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 84198 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84198

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Sacred

2-FULL NAME William Sacks

(a) RESIDENCE NO. 1321 Oakland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: — 1866 ~~1877~~

6 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
(58)	~~59~~	—	—	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hosp Records

15 FEB 26 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 24 1924

17 I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ 23 ~~1~~ 1924, to 2 - 24, 1924, that I last saw h~~e~~ alive on Feb 24, 1924, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcic infection

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Mennuger M. D.

2-24. 1924 (Address) N. Gaylor Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Feb 26 1924

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-002

D 84199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2503 E. Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Lewis

(a) RESIDENCE NO. 2503 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Samuel D. Lewis

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Kehoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Finlong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Samuel D. Lewis

(Address) 2503 E. Fayette

FEB 26 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to Feb 24, 1924

that I last saw her alive on Feb 24, 1924,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Embolism of Cerebral Vessel (Hemiplegia)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam. Chest

(Signed) B.V. Kelly, M. D.

Feb 25, 1924 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb. 27 1924

20 UNDERTAKER Jos. J. Kerr

ADDRESS 106 N. Luzerne Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84200

CERTIFICATE OF DEATH.

29 D 84200

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 405 S. High ST., 3 WARD)

2-FULL NAME Francesco Colletto

(a) RESIDENCE No. 405 S. High ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Catherine Colletta

6 DATE OF BIRTH (month, day, and year): Nov 10 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62		3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Joseph Lecey 106

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Angelo Colletto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Donana Magistro

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Jennie Bruno

(Address): 405 S High St

15 Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923 to Feb 24 1924, that I last saw him alive on Feb 23 1924, and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Johnston M. D.

1924 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Vincent Cem	Feb 27 1924
20 UNDERTAKER	ADDRESS
Frank A Pepilone	1800 E 33rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21—M&T—1500 Blks. Elmer Ray Uzzell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84201

D 84201

CERTIFICATE OF DEATH.

X 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Clare Hospital ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. R. Uzzell

(a) RESIDENCE NO. 123 Oakdale Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State) Baltimore Md

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Naomi M. Uzzell

6 DATE OF BIRTH (month, day, and year) Aug 7, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) C & P. Tel Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Albert A. Uzzell

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) N.C

12 MAIDEN NAME OF MOTHER Martha J. Musgrove

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Naomi Uzzell

(Address) 123 Oakdale Ave

FEB 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24-24

17 I HEREBY CERTIFY, That I attended deceased from 1-22-24, 19..... to 2-24-24, 19..... that I last saw him alive on 2-24-24, 19..... and that death occurred, on the date stated above, at 1 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Septic Type)

Septicemia.

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Appendicitis

..... (duration) ..... yrs. ..... mos. 28 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1-22-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Geo A Tongren, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 26 1924

20 UNDERTAKER Harry H. Weitzel — ADDRESS 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-13. H. P. Co. 1000 Bks.

D 84202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84202

CERTIFICATE OF DEATH.

154-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 W. Lexington St.: 20 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank N Hart Jr.

(a) RESIDENCE. No. 1835 W. Lexington St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank N Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Marietta Ohio

12 MAIDEN NAME OF MOTHER M. Etna Arrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank N Hart

(Address) 1835 W Lexington Street

Filed ... 19 ROBERT R. KRAUTER, Burial Permit Clerk ... Registrar

EB 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 16, 1924, to Feby 25, 1924, that I last saw him alive on Feby 23, 1924, and that death occurred, on the date stated above, at 8 20 A m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Cordis

(duration) yrs. life mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) \ yrs. \ mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no Physical Exam

What test confirmed diagnosis?

(Signed) J. M. V. Clark, M. D.

Feb 26, 1924 (Address) 1312 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 27 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins st

PLEASE WRITE PLAINLY. PHYSICIANS should state DISEASE CAUSING DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84203 100 OD 84203

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2245 N Fulton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Leo Smith

(Residence in Baltimore: No. 2245 N. Fulton Ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, March (Month) 4 (Day), 1883 (Year)

7-AGE,	If LESS than 1 day,
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Ob

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa V. Smith

(Address) 2245 N. Fulton Ave

15-

Filed ....., 191. ROBERT R. KRAUTER, Registrar.

B 261972 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9 1924, to Feb 25 1924, that I saw him alive on Feb 23 1924, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Sudden death caused by embolism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 14 ds.

(Signed) John Zerler M. D.

Feb 25, 1924 (Address) 1113 Poplar Grove

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	Feb 27, 1924
20-UNDERTAKER George J. Smith	ADDRESS 153 Hollins

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very properly classified. PHYSICIANS should state

EXHIBIT U.S.A.

Spec.—1-10-21—M&T—1500 Bks.

D 84204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84204

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Ashburton St., Ward 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Smith

(a) RESIDENCE No. 3710 Ashburton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs John Ehmann

(Address) 4504 Reisterstown Rd

FEB 26 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17

I HEREBY CERTIFY, That I attended deceased from July, 1922, to Feb 25, 1924.

that I last saw h alive on Feb 24, 1924.

and that death occurred, on the date stated above, at 6.05 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. E. Byers M. D.

25 1924 (Address) 1405 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Cem Balto Co	Feb 27 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84205

CERTIFICATE OF DEATH.

31

D 84205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Carlisle Place St., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Taylor

(a) RESIDENCE NO. 1726 Carlisle Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Walter Taylor

6 DATE OF BIRTH (month, day, and year) June 10, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or.....min.
	23	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Hickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Walter Taylor

(Address) 1726 Carlisle Pl

15 Filed FEB 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 23. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 5 1924 to Feby 23 1924 that I last saw her alive on Feby 20 16 1924 and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. T. Howells M. D.

2/26 1925 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grativille Va	Feb. 27 1924

UNDERTAKER Mrs R. G. Elliott

ADDRESS 1725 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84206

CERTIFICATE OF DEATH.

X 129 D 84206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Ashland Ave. WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Crawley

(a) RESIDENCE No. 1810 Ashland Ave WARD

(Usual place of abode)

(If non-resident give city or town and State) Virginia

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Simon Crawley

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Nottoway Co. Va.

PARENTS

10 NAME OF FATHER: Asa Suggle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: John Crawley

(Address): 813 W. Durham St

FEB 29 1924

Filed .19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/23/1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1924 to Feb. 23 1924

that I last saw h[illegible] alive on Feb. 23, 1924

and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Mitral regurgitation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno L. Robinson M. D.

, 19 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Nottoway Co. Va	Feb. 27, 1924
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84207

CERTIFICATE OF DEATH.

74 B 84207

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2609 Foster Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Smith

(a) Residence No. 2609 Foster Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 20, 1865

7-AGE. 58 yrs. 3 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Watchman

(b) General nature of industry, business, or establishment in which employed (or employer). Gibbs Packing House (Retired 4415)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Frederick J. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Bertha Weismueller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Mrs. Bertha Reitz

(Address) 2609 Foster Ave

15- Filed FEB 26 1924 ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 17 1924 to Feby 22 1924

that I last saw h[illegible] alive on Feby 21 1924

and that death occurred, on the date stated above, at 8 10 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb V. Atkey M. D

Feby 24 1924 (Address) 100 S. Potterson Park

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Matthews Cem. DATE OF BURIAL. Feb. 26, 1924

20-UNDERTAKER. F. Sander Sons ADDRESS 1710 Fleet St

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84208

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 16 Strathmore Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Louis Ortt

(a) Residence No. 16 Strathmore Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elfreda Ortt

6-DATE OF BIRTH (month, day and year) Feb. 11, 1879

7-AGE. 45 yrs. ~ mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Letter Carrier

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 086

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country)..... Md.

PARENTS:

10-NAME OF FATHER. Peter A. Ortt

11-BIRTHPLACE OF FATHER (city or town)..... Balto
(State or Country)..... Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Alvater

13-BIRTHPLACE OF MOTHER (city or town)..... Balto
(State or Country)..... Md.

14-
(Informant) Elfreda Ortt
(Address) 16 Strathmore Ave

15-
Filed ..... 192.. ROBERT R. KRAUTER, Registrar.
FEB 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 19 24 to Feb 24 19 24

that I last saw he alive on Feb 24 19 24

and that death occurred, on the date stated above, at 9 40 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis +

Mitral Regurgitation (Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Chas Simms M. D

Feb 25 19 24 (Address) 4 W Hamilton

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cem	Feb 27, 1924
20-UNDERTAKER.	**ADDRESS**
H. Lauder Sons	1710 Eutaw St

IMPORTANT. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Should state CAUSE OF DEATH so that it may be properly classified.

D 84209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 84209
Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Union Memorial Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick P. Dougherty

(Residence in Baltimore: No. 203 E. Lee St. St., yrs. 4 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Oct. (Month) 16 (Day) 19?? (Year)

7-AGE: 23 yrs. 4 mos. 7 ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sheet Metal
(b) General nature of industry, business, or establishment in which employed (or employer): Worker

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: James P. Dougherty

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Frederickke Schirmer

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Schirmer
(Address) 105 S. Durham St

15-
FEB 26 1924
ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. (Month) 23 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Injuries due to fall.
Accidental
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) John J. Morrison M. D.
(Coroner.)
1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem.	Feb. 27 1924
20-UNDERTAKER,	ADDRESS
H. Sander Sons	1710 Pleasant St

IMPORTANT—CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

Stee–12-23-21–E.B.R.S.–400 Bks.

D 84210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 84210

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 801 S. Bond St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wierzbowski

(a) Residence No. 801 S. Bond St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Weronika Wierzbowski

6-DATE OF BIRTH (month, day and year) March 18 1880

7-AGE. 43 yrs. 11 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Labor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Anthony Wierzbowski

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland

14-

(Informant) Mrs. Weronika Wierzbowski

(Address) 801 S. Bond St.

FEB 26 1924

ROBERT E. KRAUTH, M. D.

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1924 to Feb. 25, 1924

that I last saw h— alive on Feb. 25, 1924

and that death occurred, on the date stated above, at 10-15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

.....(Duration) yrs. 2 mos. ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? P.S.+S.

(Signed) John J. Kruger M. D.

, 19 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	Feb 27, 1924
20-UNDERTAKER.	ADDRESS
Lehman Weber	1803 Bank St.

If not properly filled, or if certificate is incomplete in any essential particular, so that it may be properly classified. See instructions on back of certificates. PHYSICIANS should state CAUSE OF DEATH in such terms as to indicate exactly the disease, and the exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 84211

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1017 S. Binney St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Anna . Majerowicz

(a) Residence No. 1017 S. Binney St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 20 1924

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Md.

PARENTS.

10-NAME OF FATHER, William . Majerowicz

11-BIRTHPLACE OF FATHER (city or town)... Baltimore...
(State or Country)... Md.

12-MAIDEN NAME OF MOTHER, Leokadia. Sklada

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Oregon

14-

(Informant)... Mr William . Majerowicz

(Address)... 1017 S. Binnej

FEB 26 1924 ROBERT N. KRAUTER,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 25/24

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1924, to Feb 25, 1924, that I last saw h.. alive on Feb 25, 1924, and that death occurred, on the date stated above, at 830 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility.

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. — ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank Janowski M. D.

2/26, 1924 (Address) 248 Fairfax

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	Feb. 27, 1924

20-UNDERTAKER,	ADDRESS
John A Weber	1803 Bank St

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See that PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified.

D 84212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84212

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 W. Lombard St. 18 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Peter McCourt

(Residence in Baltimore: No. 915 W Lombard St.; yrs. 68 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH. May (Month) (Day) 1855 (Year)

7-AGE. 68 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rigger in marble
(b) General nature of industry, business, or establishment in which employed (or employer): works of John J. Flynn

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Peter McCourt

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Bridget Cassidy

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cornelius Sullivan

(Address) 915 West Lombard Street

15- FEB 26 1924 ROBERT M. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 25 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held nn ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. Don't know mos. ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) W. B. Branch M. D. (Coroner.)

2.25 1924 (Address) 117 N. Sandtown St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Feb 28" 1924

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Bath St

Is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. ...in plain terms, so that it may be ...

REG. No. 1778 DR. H. R. [illegible] 117 W. SARATOGA STREET

PHONE, CALVERT 2650

OFFICE HOURS: 9 TO 12 A. M., 3 TO 5 AND 7.30 TO 9 P. M.
SUNDAYS, 9 TO 11 A. M. ONLY

PATIENT'S NAME .....

ADDRESS .....

R 4. 2 3 4

I am informed that
the age of 73 years in case
of Peter McCourt 915 N.
Lombard who died Feb 25
1924 is incorrect that his
correct age was 68 yrs.

H R Gorsuch

SPETZLER DRUG CO.
RELIABLE PHARMACISTS
H. C. SPETZLER FRED W. FINK
123 W. Baltimore St., Cor. Hopkins Place, Baltimore

M. D.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84213

CERTIFICATE OF DEATH.

101-001

D 84213

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 541- Gold ST. 15 WARD)

2-FULL NAME Edward Henry Kennard

(a) RESIDENCE. NO. 541- Gold ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Kennard

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Baltimore Copper Wks.

9 BIRTHPLACE (city or town) (State or country) North Humberland Co. Va.

PARENTS

10 NAME OF FATHER Henry Kennard

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Humberland Co. Va.

12 MAIDEN NAME OF MOTHER Eliza Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Humberland Co. Va.

14 Informant Mrs. Lula E. Cooper
(Address) 541 Gold St

15 Filed FEB 26 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 19 24

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 19 24, to Feb. 24, 19 24, that I last saw h[e]r alive on Feb. 24, 19 24 and that death occurred, on the date stated above, at 1:55 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) L. A. Coleman, M. D.

19 (Address) 211-E-20 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Feb 27 19 24

20 UNDERTAKER John H Davidson — ADDRESS 1027 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84214

CERTIFICATE OF DEATH.

31 ✓ D 84214

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2519 Laurette ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Kirkwood

(Residence in Baltimore: No. 2519 Laurette ave. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, Sept. 1, 1898
(Month) (Day) (Year)

7-AGE, 25 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Auto supplies

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob Kirkwood

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Ella Donaldson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs May Kirkwood

(Address) 2519 Laurette ave

15- FEB 2 6 1924 ROBERT R. KRAUTER,

Dic. ....., 191... Burial Permit ~~Clerk~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 23, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924, to Feb 23 1924, that I saw him alive on Feb. 23 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Septic
Pneumonia

(Duration) ....yrs. ....mos. 23 ds.

CONTRIBUTORY (Secondary) Acute Tuberculosis

(Duration) ....yrs. ....mos. ? ....ds.

(Signed) Thos. H. Paddleford M. D.

....., 191... (Address) 2300 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem — DATE OF BURIAL, Feby 26, 1924

20-UNDERTAKER John C Mitchell — ADDRESS 1201 W Fayette

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Karow

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84215 — CERTIFICATE OF DEATH. — 129 D 84215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. 6 WARD)

2-FULL NAME Mrs Anna Belle Karrow

(a) RESIDENCE NO. Savannah Ga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Edward Karrow

6 DATE OF BIRTH (month, day, and year) Nov 14 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House Duties

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Claude Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Catherine Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant R Lester Karrow

(Address) Savannah Ga

15 Filed FEB 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1924, to Feb 25 1924, that I last saw h[illegible] alive on Feb 25 1924, and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH was as follows:

1 Arteries Sclerosis

Hypertension

Chronic Nephretis (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis (duration) yrs. mos. 1 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) Gaylard Carleton, M. D.

, 19 Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Savannah Ga — DATE OF BURIAL Feby 26 1924

20 UNDERTAKER John O. Mitchell — ADDRESS 1201 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84216

CERTIFICATE OF DEATH.

90 ✓ D 84216

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1741 Bank St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Eashmyer

(a) Residence No. 1741 Bank St., 2 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 28th 1865

7-AGE. 58 yrs. 4 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Former School

(b) General nature of industry, business, or establishment in which employed (or employer)..... Teacher

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Henry Eashmyer

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Elizabeth Limbert

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or Country).

14- (Informant) Henry A. Eashmyer

(Address) 1741 Bank St.

15- FEB 26 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 25th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 25 1923 to Feb 25 1924

that I last saw h.....alive on..... 19....

and that death occurred, on the date stated above, at 8.35 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(Duration).....yrs. 2 mos.....ds.

18-Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. F. Burke M. D.

Feb 25. 1924 (Address) 3042 Hudson St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	Feb. 28 1924
20-UNDERTAKER.	ADDRESS
Lilly + Zeiler	4033 Wolfe St.

Classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 34217.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84217.

CERTIFICATE OF DEATH.

74-081

1-PLACE OF DEATH

City of BALTIMORE: (No. 935 S. Fell St., 2 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabette E. Cronhardt

(a) Residence No. 935 S. Fell St., 2 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 8 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of the late John H. Cronhardt

6-DATE OF BIRTH (month, day and year) July 17th 1850

7-AGE. 73 yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Balto. Co. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER. John Kephart.

11-BIRTHPLACE OF FATHER (city or town). Germany
(State or Country).

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town). Germany
(State or Country).

14-

(Informant). Emma L. Krauter

(Address) 935 S. Fell St

Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 25th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1923 to Feb 25th 1924

that I last saw h.. alive on Feb 25th 1924

and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 4 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert Strauss, M. D

2-25, 1924 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cemetery. DATE OF BURIAL. Feb. 27 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

In case of DEATHS DURING LABOR, be careful to state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001
101 D 84218

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Frank

(a) Residence No. 726 W Hamburg St St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs Nora Frank

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 67 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Denmark

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

11- (Informant) Mrs Nora Frank

(Address) 726 W Hamburg St

FEB 26 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26-24

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 19 24 to Feb 26 19 24

that I last saw h[illegible] alive on Feb 26 19 24

and that death occurred, on the date stated above, at 3 15 AM m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) S. Goldman M. D

19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Peters Cem	2-29 19 24
20-UNDERTAKER. James Dignan & Son	ADDRESS 1000 E Pasa St

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84219 CERTIFICATE OF DEATH. 101-001 D 84219

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302-Cumel ST. 11 WARD)

2-FULL NAME Mrs Mamie L. Infant Foldey

(a) RESIDENCE No. 302-cumel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/21/24

7 AGE Years Months Days: 2 If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Foldey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co md

12 MAIDEN NAME OF MOTHER Edith Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge md

14 Informant Edith Hunt Foldey

(Address) 302-Cumel

15 Filed FEB 2 6 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1924, to Feb 23, 1924, that I last saw him alive on Feb 23, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Bilateral

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Signs

(Signed) Walter D. Jackson, M. D.

, 19 (Address) 1618 W-mulb

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 26 1924

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84220

38

D 84220

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Douglas Morgan

(a) RESIDENCE NO. 1821 Lumprich St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb 7, 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond D. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alberta Gavens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar

1566 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 20, 1924, that I last saw him alive on Feb 20, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hereditary syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann

(Signed) H. H. Weech, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health, FEB 25 1924

CAUSE OF DEATH in plain terms, so that it should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Harris)

D 84221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84221

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1104 Fayette Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F Harris

(a) Residence No. 1104 Fayette Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1st 1847

7-AGE 77 yrs. mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Ellen Hanby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Gary Thomas

(Address) 733 Eager St

15- Filed FEB 26 1924 KOBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 24, 1924

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1924 to Feb 24, 1924

that I last saw him alive on Feb 23, 1924

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Endocarditis + nephritis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. R. Galbraith M. D.

, 19 (Address) 727 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL, 2-26, 1924

20-UNDERTAKER Geo. F. A. Gibson ADDRESS 1101 Druid

INSTRUCTIONS: PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Prince

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84222

CERTIFICATE OF DEATH.

15 124 D 84222

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15-32 N Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caleb Purcell

(Residence in Baltimore: No. 15-32 N Carey St.; 2 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, August 30, 1854
(Month) (Day) (Year)

7-AGE, 69 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Purcell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harkinson

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie Purcell

(Address) 15-32 N. Carey St.

15-

Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Co...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 23 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/24 1924, to 2/23 1924, that I saw h[im] alive on 2/23 1924, and that death occurred, on the date stated above, at 11:25 P m.

The CAUSE OF DEATH* was as follows:

a. Influenza

b. Pneumonia

.....

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Jno. R. Lee M. D.

2/25, 1924 (Address) 1130 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Interment in Cy

DATE OF BURIAL, 2-27, 1924

20-UNDERTAKER George T. Gilson

ADDRESS 1133 Druid Hill Ave

IMPORTANT: PHYSICIANS should state plainly and PRECISELY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D 84223

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Renick

(a) RESIDENCE NO. R.F.D. Chillicothe ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of George W. Renick

6 DATE OF BIRTH (month, day, and year) Oct 21st 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Jimmy Thurno

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Emma E. Grubb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant George Renick
(Address) Chillicothe Ohio

15 FEB 2 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to Feb 26, 1924,

that I last saw her alive on Feb 26, 1924,

and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4 years duration

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood

(Signed) Jay Mark, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chillicothe Ohio — DATE OF BURIAL: Feb 26 1924

20 UNDERTAKER: W. H. Jenkins & Bro Co — ADDRESS: Orchard & Mt Vallonia St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84224

CERTIFICATE OF DEATH.

D 84224

REGISTERED NO. X188-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Steel

(a) RESIDENCE NO. 1826 McCulloughST., WARD West Indies
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col. | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 1896

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West India Islands

PARENTS

10 NAME OF FATHER Unsteele

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. I. Island

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ethyn Cohen (Address) 1826 McCulloch St

15 Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 192X

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Femur.
Cerebral Embolism —
as a result of (duration) Short yrs. 1 mos. Few days ds. Auto Accident

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) H. C. Kelly, M. D.
(Coroner.)
Feb. 26 192X (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos., ds. State 10 the yrs. 7 mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL 2/26/24

20 UNDERTAKER Sam'l Hemsley | ADDRESS 1826 Bolton

IMPORTANT. PHYSICIANS should state name, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84225

CERTIFICATE OF DEATH.

90 D 84225

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Madison Ave ST., 14 WARD)

2-FULL NAME Mrs. Tobie Silberman

(a) RESIDENCE NO. 2000 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tobie Silberman

6 DATE OF BIRTH (month, day, and year): about 1838

7 AGE: Years: about 86 yrs. Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Soloman Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Beila Kann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Tauchem Silberman
(Address) 2000 Madison ave

15 FEB 26 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

about 2 yrs. mos ds. (duration)

CONTRIBUTORY (Secondary): no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Feb. 26, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Benev. Assn. DATE OF BURIAL: 2/26/24

20 UNDERTAKER: Jack Levin ADDRESS: 1939 E. Baltimore

IMPORTANT: This certificate may be properly classified. PHYSICIANS should state ... See instructions on back of certificate. Exact statement of OCCUPA...

Spec.—1-10-21—M&T—1500 Bks.

Lamar.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84226

CERTIFICATE OF DEATH.

29

D 84226

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1526 Hillman ST., 24 WARD)

2-FULL NAME Bridget A. Lamar

(a) RESIDENCE NO. 1526 Hillman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~
~~How long did~~
(or) WIFE of George H. Lamar

6 DATE OF BIRTH (month, day, and year) Mar 25 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	69	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Housework~~ None 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George H. Lamar
(Address) 1526 Hillman St

15 FEB 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1923, to Feby 24, 1924, that I last saw ~~her~~ alive on Feby 23, 1924, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) W. D. Knight, M. D.

Feby 24, 1924 (Address) 109 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	2/28 1924
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1310 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84227.

CERTIFICATE OF DEATH.

X 84 D 84227.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME George Long.

(a) RESIDENCE NO. Timberpark W. Va. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hazel Long

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter O'S

(c) Name of employer .....

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER James Long.

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wyndmiller

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hospital Record.
(Address)

FEB 26 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/24

17 I HEREBY CERTIFY, That I attended deceased from 2/16/1924, to 2/26/24,
that I last saw h— alive on 2/26/24, 19
and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Probably Brain Tumor.

.....(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 2/25/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gilley, M. D.

(Address) Mercy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg W Va	2/26/1924
20 UNDERTAKER	ADDRESS
George E Talbot & Sons	Baltimore

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84228

CERTIFICATE OF DEATH.

99-007 ✓ D 84228

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5310 Clemmore St. (Ward) 27

2-FULL NAME Mr ~~Board~~ Mrs F Wantz

(a) RESIDENCE No. 5310 Clemmore St. Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) July 4, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm G Wantz

(Address) 5310 Clemmore Ave

15 Filed FEB 26 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25th 24

17

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1924, to Feb 26, 1924, that I last saw him alive on Feb 25, 1924, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 + yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Chas B. Turner M. D.

2025 1924 (Address) 5016 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel Bulls Co	Feb 28 1924

20 UNDERTAKER GRENOWETH & SON ADDRESS 2617 CHESTNUT AVE

CAUSE OF DEATH in plain terms. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Ruby · O'Dell ·

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84229

CERTIFICATE OF DEATH.

X45 D 84229

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Ruby O'Dell

(a) RESIDENCE NO. Richwood W. Va. ST., ... WARD A3

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Depswell W Va

PARENTS

10 NAME OF FATHER Jacob O'Dell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Depswell W Va

12 MAIDEN NAME OF MOTHER Lenora McClung

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sandridge

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed FEB 26 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26-24 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Feb 26, 1924, that I last saw h[illegible] alive on Feb 26, 1924, and that death occurred, on the date stated above, at 3:10 m.

The CAUSE OF DEATH* was as follows:

Retro Sternal Sarcoma

(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Richwood W Va.

Did an operation precede death? No Date of None

Was there an autopsy?

What test confirmed diagnosis? X-Ray. Blood Work.

(Signed) Robert W. Mickum, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richwood, Nicholas Co, W. Virginia	Feb 26, 1924
20 UNDERTAKER	ADDRESS
Wm Cook	50 x 6 Mon Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should be sure that all of information is very important that it may be properly classified. Exact statement of OCCUPATION on back of certificates.

Spec.—6-9 19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84230

CERTIFICATE OF DEATH.

D 84230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 Lakewood Ave. St. Lakeland Dist. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Zeun

(a) RESIDENCE. NO. 1224 Lakewood Ave. ST. Lakeland WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Zeun

6 DATE OF BIRTH (month, day, and year): March 18th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germy

PARENTS

10 NAME OF FATHER: John A. Trunkenwitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: August F. Lehner

(Address): 1224 Lakewood Ave. Lakeland

15 Filed FEB 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24th 1924

17

I HEREBY CERTIFY, That I attended deceased from December 15th 1923, to Feb. 24th 1924.

that I last saw her alive on Feb. 23rd 1924

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis and chronic aortic insufficiency

(duration) — yrs. 2 mos. 9 ds.

CONTRIBUTORY (Secondary): Dilatation of heart

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Reichel M. D.

2/26 1924 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 27 1924
20 UNDERTAKER	ADDRESS
E. Lehlman & Son	1039 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84231

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 84231

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 746 Wilmington ST., 4 WARD)

2-FULL NAME Emilie Konow

(a) RESIDENCE NO. 746 Wilmington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Konow

6 DATE OF BIRTH (month, day, and year) April 1. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) ..... (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Tribell

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Nicke

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Harry C. Konow
(Address) 1921 Windsor Ave.

15 Filed Feb 26 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to Feb 25th 1924

that I last saw her alive on Feb 24th 1924

and that death occurred, on the date stated above, at 9:09 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Old age

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Leon W. Hernandez M. D.

Feb 26 1924 (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 28th 1924
20 UNDERTAKER	ADDRESS
E Schlomann & Son	Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-D-1—M&T—1500 Bks.

1696 8

D 84232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84232

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin O Beatty

(a) RESIDENCE No. 24 Elgin St. Welland, Canada

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jannie Beatty

6 DATE OF BIRTH (month, day, and year) Nov 23 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Nathan Beatty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Luveaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924 to Feb 26, 1924.

that I last saw h[illegible] alive on Feb 26, 1924

and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shaw M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Welland Ontario Canada — DATE OF BURIAL Feb 26 1924

20 UNDERTAKER John O Mitchell — ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84233

CERTIFICATE OF DEATH.

X 188-003

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Elias Jacobs

(a) RESIDENCE NO. Brooklyn, N.Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mollie Jacobs

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

045

9 BIRTHPLACE (city or town)
(State or country) Romania

PARENTS

10 NAME OF FATHER Jacob Jacobs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie ----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14
Informant Dr. Harry Jacobs
(Address) Brooklyn, N.Y.

3 26 1924, 192 Robert F. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Fracture Skull.
Automobile accident

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (over)

(duration) yrs. mos. ds.

(Signed) J. H. Walter (Coroner) M. D.

Feb 26, 1924 (Address) 308 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York	2/26 1924

20 UNDERTAKER Jack Lewis 1439 ADDRESS Eutaw

INFORMATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84234 ✓ D 84234

CERTIFICATE OF DEATH.

148

1-PLACE OF DEATH Christ's Institution Hospital

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 704 to Ember ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hanna M. Zowdeski

(a) RESIDENCE NO. 710 W. Lexington ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 7 mo. 28 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Zowdeski

6 DATE OF BIRTH (month, day, and year) Nov 24 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Philada
(State or country) Pa

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Joseph Zowdeski
(Address) 710 W. Lexington St

Filed 2 6 1924, 192 ..... Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Anaemia
Convulsions typhoid fever
24 hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ....., M. D. (Coroner.)
Feb. 26 1924 (Address) 1659 Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 27 1924

20 UNDERTAKER	ADDRESS
J. W. & Wm. J. W. Turpin & Son	801 W. Fayette

IMPORTANT is very important. See instructions on back of certificate.

important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84235

CERTIFICATE OF DEATH.

90 D 84235

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Birchwood av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Kronsler

(Residence in Baltimore: No. 111 Birchwood av St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Feb. (Month) 5 (Day), 1857 (Year)

7-AGE. 66 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker.
(b) General nature of industry, business, or establishment in which employed (or employer): Bakery

9-BIRTHPLACE. (State or Country). City

PARENTS.

10-NAME OF FATHER. John Kronsler

11-BIRTHPLACE OF FATHER (State or Country). Nat Known

12-MAIDEN NAME OF MOTHER. Nat Known.

13-BIRTHPLACE OF MOTHER (State or Country). Nat Known.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kin Kronsler

(Address) 111 Birchwood av

15- Robert P. Harrison, 191.... Registrar.

261924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 24 (Day), 1914 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1913, to Feb 24 1914, that I saw h.. alive on Feb 24 1914, and that death occurred, on the date stated above, at 5.05 P m.

The CAUSE OF DEATH* was as follows:

Valvular Endocarditis

(Duration)...1...yrs.....mos...13...ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Jacob Frohn M. D.

Feb 25, 1914. (Address) 1023 N Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Linden Park.	2/27, 1914

20-UNDERTAKER: E J Dunning & Son 1938 — ADDRESS: Eutaw & Pratt

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84236

CERTIFICATE OF DEATH.

90 D 84236

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Froine

(a) RESIDENCE NO. — Unknown ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) ..... Chester
(State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14
Informant .....
(Address)

15 Filed 2 6 1924, 192... Robert F. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopay or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopay or inquiry.) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Valv. dis. Heart

Instant (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lung Suddenly

(duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner.)

2-26, 192 4 (Address) 1057 Cary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL
St. Paul, Pikesville.

DATE OF BURIAL
2/26/1924

20 UNDERTAKER
E. J. Fanning & Son - 1938 E. Lafayette Ave.

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84237

CERTIFICATE OF DEATH.

90 D 84237

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 Linden av ST., 14 WARD)

2-FULL NAME Pauline P Levy

(a) RESIDENCE NO. 1936 Linden av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maurice Levy

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 237

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Manuel Peppercorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Fanie Peppercorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14

Informant Maurice Levy
(Address) 1936 Linden ave

15

Filed 3 26 1924 Robert P. Harrison Registrar

Social Servit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26th, 1924, to Feb. 26, 1924, that I last saw her alive on Feb 26, 1924, and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Gr than 30 minutes
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Myocarditis
(duration) Natural yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. W. Keown, M. D.

3/26/1924 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shelt Sholom	Feb 25 1924
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state plainly supplied. AGE

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84238

D 84238

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH n.

CITY OF BALTIMORE: (No. 128 Washington ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kough

(a) RESIDENCE. No. 128 N. Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonia Kough

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	\	\	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Meats

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bonnhena

PARENTS

10 NAME OF FATHER Joseph Kough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bonnhena

12 MAIDEN NAME OF MOTHER Annie Bandle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bonnhena

14 Informant Frank Kough

(Address) 815 N Streeper St

15 Filed Robert P. Harrison, Registrar

261924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/2 1923, to 2/24 1924, that I last saw him alive on 2/24 1924, and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J H Bailey, M. D.

2/24 1924 (Address) 1846 S. Dallas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 27 1924
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

COPY

Spec—12-23-21—E.B.R.S.—400 Bks.

(Garver) ✓

D 84239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84239

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2203 N. Charles St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Percy H. Garver

(a) Residence No. 2203 N. Charles St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widower

5a-If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Anna Garver

6-DATE OF BIRTH (month, day and year) Jan 25, 1866

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER. Daniel Garver

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER. Maria Stiffler

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14-

(Informant)... Howard H. Garver

(Address)... 2203 N. Charles St.

15-

Filed ..... 192 Robert F. Harrison, Registrar.

FEB 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 25/24

17- I HEREBY CERTIFY, That I attended deceased from Oct ....., 19 21, to Feb 25, 19 24

that I last saw him alive on Feb 25, 19 24,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 40 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(Duration) Unknown mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of.....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. R. Traynor, M. D.

, 19 (Address) 2429 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn — DATE OF BURIAL, Feb 27, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 501 E Monument

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84240

CERTIFICATE OF DEATH.

71-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital (ST., 17 WARD)

2-FULL NAME Ida Nolan

(a) RESIDENCE NO. 1721 N. Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed,~~ or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Nolan

6 DATE OF BIRTH (month, day, and year): Jan 7/1888

7 AGE: Years 36 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife 137

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Ferdinand Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie Dettrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Jeanette Kobler

(Address): 1002 E. Eutaw Street

15 ..... 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/26/24 19

17

I HEREBY CERTIFY, That I attended deceased from 2/23/24, 19..., to 2/26/24, 19 ,

that I last saw h- alive on 2/26/24, 19 ,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Bacteremia

Spinal Meningitis.

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Dooley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemy

DATE OF BURIAL: Feby 29 1924

20 UNDERTAKER: William Cook

ADDRESS: 502 E Eutaw

B 26 1924

Burial Permit Clerk.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 84241 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84241

100-08

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clarence Reinhard

(a) Residence No. 3229 E. Baltimore St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1876

7-AGE.	If LESS than 1 day,
48 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country),

11-

(Informant) Municipal Hospital Records

(Address)

15-

Filed 2 6 1924 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-26-24

17- I HEREBY CERTIFY, That I attended deceased from 2-23, 1924 to 2-26, 1924 that I last saw him alive on 2-25, 1924 and that death occurred, on the date stated above, at 1 30 A. M. The CAUSE OF DEATH* was as follows:

Acute and Chronic Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Brace M. D

2-26. 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Oak Lawn	Feb 28, 1924
20-UNDERTAKER,	ADDRESS
William Cook	502 E Natl a

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Blks.

Dr Emma Gondon ✓

B 84242 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 129 D 84242

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 216 Furrow St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman John Heibs

(a) Residence No. 216 Fulton. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) S.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 25 1915

7-AGE. 8 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER Herman Heibs

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Grace Baxter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Carroll County Md

14-Informant Herman Heibs

(Address) 216 Furrow St.

15-Received Feb 26 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1923 to Feb 25, 1924

that I last saw him alive on Feb 25 1924

and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Condon, M. D.

, 19 (Address) 150 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL Feb 27th 1924

UNDERTAKER. F. B. Skippert ADDRESS 2236 Frederick Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84243

CERTIFICATE OF DEATH.

46 D 84243

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3604 Kossuth St., 20 WARD)

2-FULL NAME Mary C. Zinker

(a) RESIDENCE NO. 3604 Kossuth ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Zinker

6 DATE OF BIRTH (month, day, and year) Dec 25-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

037

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER E Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Funk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant David Zinker
(Address) 3604 Kossuth St

15 Filed 2-6-1924 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1924, to Feb 26, 1924, that I last saw h.. alive on Feb 26, 1924 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of April 1923

Was there an autopsy? ——

What test confirmed diagnosis? ——

(Signed) Howard W. Jones M. D.

(Address) 222 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Still Pond Kent County Md DATE OF BURIAL Feb 28 24

UNDERTAKER J. B. Hepburn ADDRESS 2256 Eutaw Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEPARTMENT RECORD. Every item of information supplied. AGE

Spec.—1-10-21—M&T—1500 Bks. Get Transcript

D 84244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 84244

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

2-FULL NAME Mary Feige

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE: Years 63 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER Andrew Feig

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Germany

12 MAIDEN NAME OF MOTHER Magdeline Granger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Germany

14 Informant Municipal Hospital Records (Address)

FEB 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-28, 1921, to 2-26, 1924

that I last saw her alive on 2-25, 1924

and that death occurred, on the date stated above, at 5-15 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Rt. Hemiplegia (Cerebral Hemorrhage)

(duration) 2¼ yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Druce, M. D.

2-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 2/28/24 19

20 UNDERTAKER: H. E. Hughes — ADDRESS: 424 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84245

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Broadway ST., 1 WARD)

2-FULL NAME Lieberman Garfinkel

(a) RESIDENCE NO. 910 N. Broadway

(Usual place of abode)

WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~ Rose Garfinkel

6 DATE OF BIRTH (month, day, and year) ——— 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gold miner.

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Harry Garfinkel

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Jamie

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Mary Gotthelf

(Address) 910 N. Broadway

15 Filed FEB 27 1924 ROBERT R. KRAUSER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1923, to Feb. 26, 1924, that I last saw him alive on Feb. 25, 1924, and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis + Chronic Interstitial nephritis —

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis and Emphysema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation.

(Signed) Davis Franklin M. D.

2/26 1924 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	2/27 1924
20 UNDERTAKER	ADDRESS
Jacob Lewis	1439 E. Baltimore St

CAUSE Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16896 D 84246

CERTIFICATE OF DEATH.

49 D 84246

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., WARD)

2-FULL NAME Lewis Mitnick

(a) RESIDENCE NO. 310 S. Caroline St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state PERMANENT RECORD. Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sallie Mitnick

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jake Mitnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar

FEB 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1924, to Feb 25, 1924.

that I last saw him alive on Feb 25, 1924.

and that death occurred, on the date stated above, at 11.05 P.m.

The CAUSE OF DEATH* was as follows:

Hypernephroma (?)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Metastases to bones, kidney, etc.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lashon-Rosedale — DATE OF BURIAL Feb 27 1924

20 UNDERTAKER Jack Lewis, 1439 E. — ADDRESS Balto.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-801

D 84247

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1331 E Clement St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME June Frances Wharram

(a) Residence No. 1331 E Clement St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 1. 1924

7-AGE. ...yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or ...min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto

(State or Country), Md

PARENTS.

10-NAME OF FATHER. Wm G Wharram

11-BIRTHPLACE OF FATHER (city or town) Balto

(State or Country), Md

12-MAIDEN NAME OF MOTHER. Panaym Kennedy

13-BIRTHPLACE OF MOTHER (city or town) Balto

(State or Country), Md.

14-

(Informant) Wm G Wharram

(Address) 1331 E Clement St

15-

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

FEB 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 25-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 23 19 24 to Feb 25 19 24

that I last saw h[illegible] alive on Feb 25 19 24

and that death occurred, on the date stated above, at 10.10 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos A Stevens M. D

2/26 19 24 (Address) 2818 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	Feb 27 1924
20-UNDERTAKER.	ADDRESS.
John F Denny	715 Light St

In plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. should state CAUSE OF DEATH EXACTLY. PHYSICIANS Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D 84248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84248

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cathedral apts. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Louisa Crane Woods.

(a) RESIDENCE NO. Cathedral & Little Chase ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (~~HUSBAND~~ of or) WIFE of: Daniel C. Woods

6 DATE OF BIRTH (month, day, and year): Sept 15-1846

7 AGE — Years: 77 — Months: 5 — Days: 11 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Judson Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Susan Maria Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Mrs. Chas. T. Crane (Address) Cathedral apts.

15 Filed FEB 27 1924 ROBERT R. KRAUTER, Burial Permit Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 20th, 1924, to Feb 26th, 1924, that I last saw her alive on Feb 25th, 1924, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Acute Bronchitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Arthritis Deformans, Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) J. A. Chatard, M. D.

Feb 26 1924 (Address) 600 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 2-28 1924

20 UNDERTAKER: Geo. W. Jenkins & Son Co — ADDRESS: McCulloh & Orchard.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84249

CERTIFICATE OF DEATH.

101-001

D 84249

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE (No. Lombard & Greene ST., 17 WARD)

2-FULL NAME Henry Harry A Webber

(a) RESIDENCE NO. 433 Fulchester Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word) Widowed Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Sept 5 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	68	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Work for 4 yrs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte N.C.

PARENTS

10 NAME OF FATHER Peter Webber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Clancy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant (Address) University Hospital Lombard & Greene Sts Balto

15 Filed FEB 27 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26th 1924

17

I HEREBY CERTIFY, That I attended deceased from 2/13/24 19 , to 2/26/24 19 ,

that I last saw him alive on 2/26/24 , 19 ,

and that death occurred, on the date stated above, at 12 35 A.M. m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) W Wallace Walker, M. D.

, 19 (Address) University Hospital Lombard & Greene Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte N. C.

DATE OF BURIAL Feb 27 1924

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts

CAUSE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84250 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84250

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 N Eden St., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward H Floyd

(a) RESIDENCE NO. 626 N Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Rosa B. Floyd.

6 DATE OF BIRTH (month, day, and year) March 22 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Basket factory

(c) Name of employer Vienna Basket Co. Estom Md.

9 BIRTHPLACE (city or town) (State or country) Rochester Co

PARENTS

10 NAME OF FATHER Edward Floyd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Rosa B. Floyd.

(Address) 626 N. Eden st.

15 Filed FEB 27 1924 ROBERT M. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1924, to Feb 23, 1924.

that I last saw h alive on Feb 23, 1924,

and that death occurred, on the date stated above, at 6 55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis Tubercular

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Pulm. T.B. unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Young, M. D.

2/25 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md DATE OF BURIAL Feb 27 1924

20 UNDERTAKER Wm R Elliott ADDRESS 125 Ashland Ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84251 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84251

CERTIFICATE OF DEATH.

REGISTERED NO. 114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 N. Broadway ST., 8 WARD)

2-FULL NAME Anna E. Hobbs

(a) RESIDENCE No. 1215 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scalp Specialist

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel H. Stobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Rebecca Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs Clara H. Stupfel 1215 N. Broadway

15 FEB 27 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 25 19 24

17 I HEREBY CERTIFY, That I attended deceased from Jany 29 19 24 to Feby 25 19 24, that I last saw h alive on Feby 25 19 24 and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Ross, M. D.

Feby 26 19 24 (Address) 1211 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Feb 28 1924

20 UNDERTAKER Henry Lutz ADDRESS 203 N. Broadway

IMPORTANT: THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84252 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 49 D 84252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 420 N. Chester St. 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fulton W. Pritchett

(a) Residence No. 200 N. Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Charlotte Pritchett

6-DATE OF BIRTH (month, day and year) Dec 19 1897

7-AGE. 26 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Fairfield Dr
(c) Name of employer: Leary

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Wm. R. Pritchett

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Minnie Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant) Wm. R. Pritchett
(Address) 200 N. Chester St.

15- Filed FEB 27 1924 192.. ROBERT F. KRAUTER, Registrar. Bureau of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 25 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 19 1923 to Feb 25 1924

that I last saw him alive on Feb 25 1924

and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of testicle

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Metastasis to lungs & abdomen

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gerry M. D

2/26 1924 (Address) 6 W. Mt. Vernon Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Interred Cem	Feb 28 1924
20-UNDERTAKER. Philip Young	ADDRESS 2510 Orleans St

In plain terms, so that it may be properly classified. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84253

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 N. Washington St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Mulfinger

(a) Residence No. 805 N. Washington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Late Sarah

6-DATE OF BIRTH (month, day and year) Jan 10 1862

7-AGE. 62 yrs. 1 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Night Patrolman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Police Dept

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John T. Mulfinger

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

11-(Informant) Mrs R. Robinson

(Address) 805 N. Washington St

15-Filed FEB 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26/24

17- I HEREBY CERTIFY, That I attended deceased from 2-1-24 to 2-25-24 that I last saw him alive on 2-24-24

and that death occurred, on the date stated above, at 12 50 p m.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Nephritis

Hospital Case

Cerebral Hemorrhage

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Findings

What test confirmed diagnosis?

(Signed) J. H. Bayless M.D.

2-26-24 19 (Address) 806 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	2/28 1924
20-UNDERTAKER, Phillip Herring	ADDRESS 2016 Orleans St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ...should state CAUSE OF DEATH. Every item of information ...RECORD.

Spec.—1-10-21—M&T—1500 Bks.

D 84254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84254

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 511 McMechen ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Brown

(a) RESIDENCE No. 511 McMechen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13-1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
61	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)? (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Judie Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Bessie M. Lee

(Address) 511 McMechen St.

15 FEB 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 19 24

17

I HEREBY CERTIFY, That I attended deceased from Jan. 7, 19 24 to Feb. 25, 19 24

that I last saw h alive on Feb. 24 19 24

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Renal Disease

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bad Acidosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Test

(Signed) W. L. Camp, M. D.

, 19 (Address) 515 McMechen St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. — DATE OF BURIAL: 2/28/24

20 UNDERTAKER: Geo. T. A. Gibson — ADDRESS: 1735 Druid Hill Ave.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84255

CERTIFICATE OF DEATH.

101-001

D 84255

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 Laurens ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Holmes

(a) RESIDENCE NO. 420 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widowed

5a If married, widowed, or divorced (or) WIFE of Aug 10-1873

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	50	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina (State or country)

PARENTS

10 NAME OF FATHER S. Crawford

11 BIRTHPLACE OF FATHER (city or town) South Carolina (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) South Carolina (State or country)

14 Informant William Holmes (Address) 420 Laurens

15 Filed FEB 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 13, 1924, to Feb 25, 1924, that I last saw h alive on Feb 25, 1924, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

2/26, 1924 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemty	2/28/1924

20 UNDERTAKER Geo. T. E. Gibson ADDRESS 1735 Druid Hill Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.S.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84256

CERTIFICATE OF DEATH.

90

D 84256

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 634 N. Gilmore St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Piet

(a) Residence No. 438 E. 22nd St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary L. B. Piet

6-DATE OF BIRTH (month, day and year) May 15, 1838

7-AGE. 85 yrs. 9 mos. 11 ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). West Virginia

PARENTS.

10-NAME OF FATHER. John Piet

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Jamaica

12-MAIDEN NAME OF MOTHER. Susan McShane

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). W. Va.

11- (Informant) Harry R. Piet

(Address) 438 E. 22nd St.

15-

Filed FEB 27 1924 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to Feby. 26, 1924

that I last saw h~~is~~ alive on Feb. 25, 1924

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as ~~follows~~

General Arteriosclerosis

& Myocardial Insufficiency

(Primary)

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY Terminal Pneumonia

(Secondary)

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. T. Owens M. D

2/24 1924 (Address) 804 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Feby. 28 1924

20-UNDERTAKER. John O. Mitchell — ADDRESS 120 W. Fayette St.

In plain terms, so that it may be properly classified. AGE should be stated in YEARS, MONTHS and DAYS if under 1 year. Every item of information must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84257

CERTIFICATE OF DEATH.

179 D 84257

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1401 Penna ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Burritt

(a) Residence No. 1401 Penna Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	m	S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 2-1910

7-AGE. 13 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Phila Pa

PARENTS.

10-NAME OF FATHER, Max Burritt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Gittel Radrensky

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Jack Levis

(Address) 1439 E Balto st

15-

Filed ..... 192.....

FEB 27 1924

ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 26-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb 26, 1924

that I last saw h— alive on Feb 26 1924

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Chronic

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Chronic

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Ephraim M. D.

, 19 (Address) 1904 E Balto St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rosedale — DATE OF BURIAL. Feb. 27, 1924

20-UNDERTAKER. Jack Levis — ADDRESS 1439 E. Balto

Instructions: Every item of information must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY, if possible. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84258

CERTIFICATE OF DEATH.

9 1 1924 D 84258

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1506 E Fleet St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Goldstein

(Residence in Baltimore: No. 1506 E Fleet. St.; 38 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Unknown, 1875
(Month) (Day) (Year)

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unkown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unkown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mammie Rose

(Address) 1506 E Fleet St.

15-

Filed....., 191.... ROBERT R. KRAUTER, Registrar.

FEB 27 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 26, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Uremia Sclerosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Broken Arm Bruises

(Duration) yrs. mos. ds.

(Signed) G. L. Blades M. D.
(Coroner.)

Feb 27 1924 (Address) 3486 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, Feb 26 1924

20-UNDERTAKER J. Fenton Burbidge ADDRESS 1127 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84259

CERTIFICATE OF DEATH.

101 001 D 84259

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3330 Hudson St ST., 26 (WARD)

2-FULL NAME Catherine F. Roncau

(a) RESIDENCE No. 3330 Hudson St ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or....min.
		6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Caspar Roncau

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Reuter

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Caspar Roncau
(Address) 3330 Hudson St.

Filed FEB 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 19 1924, to Feby 25 1924,
that I last saw her alive on Feby 20 1924,
and that death occurred, on the date stated above, at 20, m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb N. Bilberg, M. D.
Feby 26 1924 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 29 1924
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84260

44 D 84260

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Allendale Road ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Fry Dozier

(a) RESIDENCE NO. 2112 Allendale Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer Johnson-Boyd & Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm R. Dozier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan F Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant T. A. Richardson
(Address) 2112 allendale Rd.

15 Filed FEB 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 19 24, to Jan 29, 19 24, that I last saw h. alive on Jan 29, 19 24, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Usual

(Signed) H. H. Hammer, M. D.

Jan 29, 19 24 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feby 1924
20 UNDERTAKER Wm Fickner & Sons	ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful in the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84261

D 84261

181-003

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chapel Gate Lane ST., Pimlico WARD 28)

2-FULL NAME Emily R. Davis

(a) RESIDENCE No. Chapel Gate Lane ST., Pimlico WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 21/93

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	6	4	

8 OCCUPATION OF DECEASED Chemist & 026

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) City Health Dept & School of Hygene

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. (State or country)

PARENTS

10 NAME OF FATHER Louis W. Davis

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. Md (State or country)

12 MAIDEN NAME OF MOTHER Rhoda Dell

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md.

14 Informant Louis W. Davis (Address) Chapel Gate Lane Pimlico

15 Filed FEB 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Feb 25, 1924, that I last saw her alive on Feb 25, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(from atherosclerosis)

Sept 11/23

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Univ. of Md. Hospital

Did an operation precede death? yes Date of Sept 11/23 Removal of Tonsils

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Krauter, M. D.

Feb 26, 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ward Chapel Balto Co Md — DATE OF BURIAL: Feb 27 1924

20 UNDERTAKER: W. J. Tuckner & Sons — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84262

HEALTH DEPARTMENT—CITY OF BALTIMORE

15 D 84262

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE. (No. 3504 Clifton St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Henry Mewshaw

(a) Residence No. 3504 Clifton Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Clara White Mewshaw

6-DATE OF BIRTH (month, day and year) Mar 10 1854

7-AGE. 69 yrs. 11 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer). 045

(c) Name of employer. J & A Mewshaw

9-BIRTHPLACE (city or town) (State or Country). Garrett Co. Md

PARENTS.

10-NAME OF FATHER. Wm Mewshaw

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England.

12-MAIDEN NAME OF MOTHER. Eva Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Mrs. Chas W. Mewshaw

(Address) 3504 Clifton Ave

FEB 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 6 , 19 24 to Feb 27 , 19 24 , that I last saw h.. alive on Feb 26 , 19 24 , and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

four days (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Osteomyelitis of leg

several (Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. C. Wedgen M. D

, 19 (Address) 1702 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cem. DATE OF BURIAL. Feb. 29, 1924

20-UNDERTAKER. Wm J. Pickerton ADDRESS North Ave

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D 84263

D 84263

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 502 Catapsco ST., 23 WARD)

2. FULL NAME Sarah L. Hartman

(a) RESIDENCE NO. 502 Catapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/21/73

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Harry Hartman

(Address) 502 Patapsco St

15 Filed FEB 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1924, to Feb 25, 1924, that I last saw h[illegible] alive on Feb 25, 1924, and that death occurred, on the date stated above, at ..m.

The CAUSE OF DEATH* was as follows:

Paten Foramen ovale

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) [illegible], M. D.

2/26, 1924 (Address) 10 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Cathedral — DATE OF BURIAL 2/27/1924

20 UNDERTAKER J. J. Fahey & Sons — ADDRESS 1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84264

CERTIFICATE OF DEATH.

90 D 84264

REGISTERED NO.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Jacob. Goldsman

(a) RESIDENCE NO. 1418 Arguith — ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances S Goldsman

6 DATE OF BIRTH (month, day, and year) May 21, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retd Office Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Sophia Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John S Goldsman

(Address) 434 Lorraine Ave

FEB 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 26. 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to Feb. 26, 1924, that I last saw him alive on Feb. 26, 1924, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & gangrene

Foot.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff. (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Oct 3. 1923

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) Harold C. Gillaspy M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feb 29 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Mt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Kiernan E. Curley.

D 84265

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 84265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 E. Preston ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME K. Curley

(a) RESIDENCE NO. 1803 Aisquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Life

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5-7			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) 057
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Hugh Curley

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Curley

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant R. Curley
(Address) 110 E Pratt

15 Filed FEB 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Femur
Arteriosclerosis
Duration Abt 2 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duration Few Hours (duration) yrs. mos. ds.

(Signed) Curley, M. D.
(Coroner.)
Feb 27, 1927 (Address) 1639 Edw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 29 1924
UNDERTAKER	ADDRESS
Richard F. Curley	1108 Guilford

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

Spec— 2-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 84266

D 84266

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Renahan

(a) Residence No. 1221 Edmondson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1846

7-AGE. 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) Municipal Hospital Records

(Address)

10- Filed FEB 27 1924, 192 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-26-24

17- I HEREBY CERTIFY, That I attended deceased from 2-16 1924 to 2-26 1924

that I last saw h. alive on 2-26 1924

and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(Duration) yrs. mos. ds.

CONTRIBUTORY Broncho-Pneumonia

(Secondary) (Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude A. Wood M. D

2-27 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Pk Crem

DATE OF BURIAL. 2-28 1924

20-UNDERTAKER. Mrs Chas A J Robb

ADDRESS 100 N Arlington Ave

Filled in carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. SEE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. SEE in plain terms, so that it may be properly classified. E instructions on back of certificates.

Spec.—10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84267

38

D 84267

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E. Henrietta ST., 23 WARD)

2-FULL NAME Salvatore Volpe

(a) RESIDENCE NO. 13 E. Henrietta ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Infant.

5a If married, widowed, or divorced
(or) WIFE of Philippina Volpe, 1/20/24

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant son

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sol Zocci

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Cesa Volpe

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Philippina Petrone

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Joseph Volpe
(Address) 13 E Henrietta

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/20, 1924, to 2/27, 1924, that I last saw him alive on Feb. 26, 1924, and that death occurred, on the date stated above, at 4. a. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
(Syphilis suspected)

(duration) — yrs. 1 mos 7 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) David Stranchen M. D.

2/27, 1924 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb 28 1924

20 UNDERTAKER Frank V. Tiptons

ADDRESS 1800 E 32nd St

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

FEB 27 1924

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 84268

D 84268

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 127 So Amity St ST.: 2 WARD)

2-FULL NAME Edward Szarek

(a) RESIDENCE. No. 127 So Amity St ST., 2 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. 38 How long in U. S., If of foreign birth? yrs. 14 mos. ds. 18

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Jan 20 - 24

7 AGE — Years: — Months: — Days: 38 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Worked gold

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Szarek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Holick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Peter Szarek (Address) 127 So Amity St

15 Filed FEB 27 1924 19 Robert F. Harris Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS mation should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 25, 1924, to Feb 26, 1924, that I last saw h. alive on Feb 26, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital debility due to Prematurity

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph A. Valentine M. D.

Feb 27 1924 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Feb 26 1924

20 UNDERTAKER: F. W. Ozgenski — ADDRESS: 1930 Eastern Ave

Spec—12-23-24—E.B.R.S.—400 Blks.

D 84269 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 84269

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, No. 1324 Mosher St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Ford

(a) Residence No. 1324 Mosher St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1863

7-AGE: 51 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS:

10-NAME OF FATHER: Wm Adams

11-BIRTHPLACE OF FATHER (City or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Brown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country): Md

11- (Informant) Celia Willy

(Address) 1324 Mosher St

15- Filed FEB 27 1924 Robert F. Maralew Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26-24

I HEREBY CERTIFY, That I attended deceased from Feb 14 1924 to Feb 25 1924

that I last saw h[illegible] alive on Feb 25 1924

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. T. Coleman M. D

, 19 (Address) 2038 McCulloh

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Baltimore Md

DATE OF BURIAL: 2-28 1924

20-UNDERTAKER: Daniel Easton

ADDRESS 9[illegible] Pa ave

8—WRITE PLAINLY. Information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Terms should be properly classified. Use only such terms as are in general use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84270

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Amity St. ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Wilson

(a) RESIDENCE. No. 212 Amity ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Jefferson Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant John Wilson (Address) 212 Amity St

Robert F. Heyer Registrar

B 2 71924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1924, to Feb 25, 1924, that I last saw h[illegible] alive on Feb 25, 1924, and that death occurred, on the date stated above, at 1045A. m.

The CAUSE OF DEATH* was as follows: Bright's Disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Albumin & Casts

(Signed) Charles A. Horsley, M. D.

Feb 26 24 (Address) 712 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2-28 1924

20 UNDERTAKER: Dan'l Easton

ADDRESS 916 Pa ave

WRITE PLAINLY, with ink. All questions must be answered. AGE should be stated EXACTLY. If unknown, approximate information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84271

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84271

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 W. Saratoga ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Emery

(a) RESIDENCE NO. 2014 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph R. Emery

6 DATE OF BIRTH (month, day, and year): May 24 1852

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) County Tyrone (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Dugan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14

Informant Mrs Mary Riley

(Address) 2014 W. Saratoga st

FEB 27 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to Feb 25 1924

that I last saw h alive on Feb 25 1924

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dialatation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Benj. Baader, M. D.

, 19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Feby 29 1924

20 UNDERTAKER: Chas. G. Black & Bro — ADDRESS: Worthington

N.B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84272

CERTIFICATE OF DEATH.

D 84272

REGISTERED NO. 101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Orleans ST.: N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Thompson

(a) RESIDENCE. NO. 3913 Orleans St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M

6 DATE OF BIRTH (month, day, and year) Feb. 27. 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Thompson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) Anarundel Co

12 MAIDEN NAME OF MOTHER Elizabeth Fenwick

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Edward Thompson
(Address) 3913 Orleans St

15 Filed ..... 19 Robert P. Harrison, Registrar

FEB 27 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1924, to Feb 25, 1924

that I last saw him alive on Feb 25, 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia (duration) X yrs. X mos. 2 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Jas. C. Friar, M. D.

(Address) 248 E 32d St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb 27, 1924

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder

21 *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates. TION is very important.

U.S.A.

Cor.—1-12-23—M&T—100 Bks.

D 84273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84273

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6th E/S Clinton ST., 1 WARD)

2-FULL NAME James R Lidard

(a) RESIDENCE No. 620 N Ellwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lunch Room
(b) General nature of industry, business, or establishment in which employed (or employer) Business
(c) Name of employer 6th & Clinton Sts

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George M. Lidard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Martha Swayne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant George Lidard
(Address) 620 N. Ellwood ave

FEB 27 1924 Filed ....., 192.... Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) Entire Complications

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] (Coroner.), M. D.

Feb 27 192[illegible] (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Feb 28 1924

20 UNDERTAKER H. Sander & Sons — ADDRESS 1710 Fleet St

mation should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts may be
TION Is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1697 D 84274

CERTIFICATE OF DEATH.

101-001 D 84274

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 19 WARD)

2-FULL NAME Clara Logan

(a) RESIDENCE No. 106 Vincent St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 8, 1922.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
1	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Logan

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Dorthy Engis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison Registrar

FEB 27 1924

[illegible] Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1924, to Feb 15, 1924, that I last saw her alive on Feb 15, 1924, and that death occurred, on the date stated above, at 3 25 9. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar) - primary

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Usual address

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bagg, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 27 19

WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84275

CERTIFICATE OF DEATH. X 179

D 84275

REGISTERED NO.....

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE (No. 1112 N. Mount ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jer. W. Olinger

(a) RESIDENCE NO. 603 East E. ST., Spurrow Pt WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) April 21, 1846

7 AGE Years 78 Months Days If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship-fitter (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pleasant River, Va.

PARENTS

10 NAME OF FATHER Pleasant Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Gudler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Olinger (Address) 603 East E St.

15 FEB 27 1924 Robert P. Harbison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1924. to Feb. 25, 1924.

that I last saw him alive on Feb. 25, 1924.

and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

several years

(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Hernia

5 days

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Study of Blood & Urine

(Signed) A. A. Smoot, M. D.

19 (Address) 412 N. Mount St. Resident Physician

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL 2/28/24

20 UNDERTAKER J. A. Moran

ADDRESS 3008 E. Baltimore St.

B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. Information as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1923
71
1852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 34276

CERTIFICATE OF DEATH.

129

D 84276

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Carlton Ave. 16 WARD)

2-FULL NAME Armintor Gray

(a) RESIDENCE No. 1211 Harlem Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Silas Gray

6 DATE OF BIRTH (month, day, and year) Mar 1852.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Denby

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Nellie Gray
(Address) 1211 Harlem Ave

15 Robert F. Harrison, Registrar
....., 19....

FEB 27 1924

Arial Pervit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1924, to July 26, 1924, that I last saw h.. alive on July 25, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chr Dist Nephritis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Clarke Jr. M. D.

July 26, 1924 (Address) 1500 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 29th 1924
UNDERTAKER	ADDRESS
Thomas E Wright	1364 Carey

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. If less than one year, state in days or hours. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Schirm)

D 84277 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84277

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1- Mortimer ave St., 27 Ward) 167-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeannie Schirm

(Residence in Baltimore: No. 1- Mortimer ave St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Dec 12 (Month) (Day) 1860 (Year)

7-AGE: 63 yrs. 6 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Penn.

PARENTS:

10-NAME OF FATHER: Wm. H. Harris

11-BIRTHPLACE OF FATHER, (State or Country): New Jersey

12-MAIDEN NAME OF MOTHER: Amelia Fields

13-BIRTHPLACE OF MOTHER, (State or Country): New Jersey

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) J. W. Schirm

(Address) 1- Mortimer ave

15-

Filed FEB 27 1924 Albert J. Harrison Registrar.

B 2 71924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas. (Poisoned.)

(Suicide)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John A. Morrison M. D.
(Coroner.)

Feb 27 1924 (Address) 3632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park DATE OF BURIAL: Feb 28 1924

20-UNDERTAKER: George L. Schwab ADDRESS 1101 Fredk. Ave.

N.B.—Every item of information should be carefully supplied. Read entire certificate so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84278

CERTIFICATE OF DEATH.

D 84278

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 150 Irving ST. (W) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta D. Getz

(a) RESIDENCE NO. 150 Irving ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Albert R. Getz

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Knuffke

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Albert R. Getz

(Address) 150 Irving St.

15 Filed 19 Registrar

Robert J. Garrison, Burial Permit Clerk.

FEB 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1924, to Feb 25, 1924, that I last saw h[illegible] alive on Feb 25, 1924, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) 222 Regent St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb. 28 1924
20 UNDERTAKER George L Schwab	ADDRESS 1101 Eutaw St.

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE information may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84279

CERTIFICATE OF DEATH.

D 84279

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE. (No. St. Agnes Hospital St., 70 Ward) 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mordecai Tillman

(a) Residence No. 424 Millington Lane Md St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara V. Tillman

6-DATE OF BIRTH (month, day and year) Mar. 21st 1860

7-AGE. 63 yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Patrolman 154

(b) General nature of industry, business, or establishment in which employed (or employer) Carroll Park

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto C. Md

PARENTS

10-NAME OF FATHER John T. Tillman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Co. Md

12-MAIDEN NAME OF MOTHER. Susanna Eskman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Co. Md.

11-(Informant) Annie Tillman

(Address) 424 Millington Lane

13-Filed ..... 192.. Robert P. Harris Registrar.

EB 27 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/25-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24 1923 to Feb. 25 1924 that I last saw him alive on Feb. 25 1924 and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Has 1 Bacillus Infection (7 days)

Prefatis Cystites (6 wks)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 2/19/24 Pa Bailey Baltimore

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H O Harper, M. D

. 19 (Address) Eldgewood Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Feb. 28 1924

20-UNDERTAKER George L. Schwab — ADDRESS 2101 Frdk. Ave.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ... instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84280 D 84280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 Main St. Hillsdale 24 ST. ..... WARD)

REGISTERED No. C 161

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Brooks

(Residence in Baltimore: No. Hillsdale Falls St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)

6-DATE OF BIRTH, Feb 27th, 1924 (Month) (Day) (Year)

7-AGE, ——— yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 40 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ———
(b) General nature of Industry, business, or establishment in which employed (or employer) ———

9-BIRTHPLACE, (State or Country). Hillsdale, Balto

PARENTS

10-NAME OF FATHER. Walter A. Brooks

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Lula E. Cross

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula A. Brooks Mother

(Address) Hillsdale Route 1

15-

Filed Feb 28 1924 E. F. Harrison, Registrar.

FEB 27 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 27 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27th 1924, to Feby 27 1924, that I saw him alive on Feb 27th 1924, and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth,
Baby 6 hrs 12 months old,
Atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ———

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jas. J. Eveleth M. D.

2/27, 1924 (Address) 1 Woodlawn Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	Feb 28, 1924
20-UNDERTAKER P. Fleckenstein	ADDRESS Mortuary

NB.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Blks.

D 84281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84281

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 Ridgley St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Villmar

(a) Residence No. 908 Ridgley St. St. Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Marr

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Villmar

6-DATE OF BIRTH (month, day and year) Nov 1853

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 83

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Mckeown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Upr Germany

12-MAIDEN NAME OF MOTHER, Mckeown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Clara Villmar

(Address) 1127 E. North Ave

15- Filed FEB 27 1924 Robert P. Harrison, Registrar.

Burial permit clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 26-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 19 24 to Feb 26 19 24

that I last saw h[illegible] alive on Feb 26 19 24

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd M. D.

2-27 1924 (Address) 642 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Feb. 29, 1924
20-UNDERTAKER. W. J. Tuckwiss	ADDRESS. Park Ave

FEB 27 1924

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84282 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84282

146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 231 N Patterson St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Gerhardt Zapp

(Residence in Baltimore: No. 231 N Patterson St St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: May (Month) 9 (Day) 1903 (Year)

7-AGE: 20 yrs. 9 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer): Seamstress 169

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Arthur Zapp

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Sadie Cyrus

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Zapp

(Address) 231 N Patterson St

15- Robert P. Harrison, 192 Registrar.

B 2 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 26 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrage + Puerperal Septicemia

From History about 1 week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know — (Duration) yrs. mos. ds.

(Signed) H K Gruwell M. D. (Coroner.)

2-27 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: St Mary's Hampden — DATE OF BURIAL: Feb 29 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E 25 Col

B.—Every item of information should be carefully supplied and should be properly classified. Exact statement of OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Patterson 2129 E Balto

D 84283 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84283

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 Rosemary Av St. Dempton Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William P. Porter

(a) Residence No. 107 Rosemary St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Barbara Porter

6-DATE OF BIRTH (month, day and year) Dec 8-1852

7-AGE, 71 yrs. 2 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): P.R.R. Co 130

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John T. Porter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rebecca Mellon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Rebecca Porter

(Address) 107 Rosemary Ave

15- Filed ..... 1924 ..... Registrar.

B 2 71924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 10 1923 to Feb 26 1924 that I last saw h.. alive on Feb 26 1924 and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Margaret Rosenbaum M. D.

Feb 27, 1924 (Address) 1124 E Balto St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, 3/29/1924

20-UNDERTAKER, William Cook — ADDRESS 502 E North

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84284 D 84284

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Gen'l Hosp. ST., 23 WARD)

2-FULL NAME Mrs Elizabeth A. Meyers

(a) RESIDENCE NO. 1636 Light St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	MARRIED

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or) WIFE of~~ John Meyers

6 DATE OF BIRTH (month, day, and year) Aug 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	49	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Accidental death — no inquest necessary — Otto M. Reinhardt M.D.

9 BIRTHPLACE (city or town) (State or country) Allegheny Co. Md.

PARENTS

10 NAME OF FATHER James A. Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Liza Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant John Meyers

(Address) 1636 Light St

15 ....., 19.... Robert P. Harris, jr., Registrar

EB 2 71924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1924. to Feb 26, 1924.

that I last saw her alive on Feb 26, 1924

and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Severe Second Degree Burns (over half of body involved).

(Gas heater)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 1633 Elizabeth Lane

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) Chas F. Blake, M. D.

, 19 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood. DATE OF BURIAL 2-29 1924

20 UNDERTAKER Jno. Cook ADDRESS 3014 North Av.

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84285

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 738 N Queen St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Jarbis Briery

(a) Residence No. 738 N Queen St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: W T Briery

6-DATE OF BIRTH (month, day and year): Nov 24 1862

7-AGE: 61 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.
10-NAME OF FATHER: Stephen Gray
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md
12-MAIDEN NAME OF MOTHER: Jacobs
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-(Informant): W T Briery
(Address): 738 N Queen

15-
Filed Feb 27 1924 Robert F. Harrison, Registrar.

Burial Forest Park

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 26-24

17- I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924 to Feb 26, 1924 that I last saw her alive on Feb 26, 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chr nephritis

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uraemia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lab

(Signed) Homer C. Todd M. D

2/27, 1924 (Address) 735 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park — DATE OF BURIAL, 2/29, 1924

20-UNDERTAKER: W F Cushwa & Son — ADDRESS: Penna Ave

B 27 1924

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-08

D 84286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1109 Race ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Jones

(a) RESIDENCE NO. 1109 Race ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hester C. Jones

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Wood dealer

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jones Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hester C. Jones (Address) 1109 Race St

15 FILED FEB 28 1924 ROBERT R. KNABE, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/1924

17 I HEREBY CERTIFY, That I attended deceased from 2/20/1924 to 2/26/1924

that I last saw h— alive on 2/25/1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Snowden, M. D.

2/24/24 (Address) 908 Druid St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 28 1924
20 UNDERTAKER	ADDRESS
Jos. T. H. Rochester	1413 Jefferson st

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be filled in. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84287.

CERTIFICATE OF DEATH.

38 D 84287

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 23 WARD)

2-FULL NAME Charles Bagley

(a) RESIDENCE NO. 1036 Leadenhall ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✗

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE: Years 45 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Matthew Bagley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Harriett Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Univ. Hospital Records

15 FEB 28 1924 ROBERT H. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1924.

17 I HEREBY CERTIFY, That I attended deceased from 1/14/24, 19..., to 2/26/, 19 24.

that I last saw him alive on 2/26/, 19 24

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac failure

Pulmonary T.B.

Amyloid Liver & ascites.

(Syphilis) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

Liver (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lancaster

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Syphilitic Liver

(Signed) John M. Edmunds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetary — DATE OF BURIAL: Feb 29 1924

20 UNDERTAKER: Jos. J. H. Rochester — ADDRESS: 1443 Jefferson St.

N. B. WRITE plainly with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84288

100-001

CERTIFICATE OF DEATH.

D 84288

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3307 Phila. Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard M. Pemberton

(a) Residence No. 3307 Phila. Av St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 1/23

7-AGE. ....yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Ed. A. Pemberton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary E. Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mary E. Pemberton

(Address) 3307 Phila av

FEB 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/27/24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15 1924 to Feb. 27 1924

that I last saw him alive on Feb. 27 1924

and that death occurred, on the date stated above, at 8:55 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Artigiani M. D

19 (Address) 2948 E. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Patrick's	2/28 1924
20-UNDERTAKER, Philip Henry	ADDRESS 2016 Orleans St

Should be carefully supplied. Exact statement of OCCUPATION is very important. Cause of death must be certified. In plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84289

CERTIFICATE OF DEATH.

94-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2940 E. Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva D. Kohl

(a) Residence No. 2940 E Monument St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 10 23

7-AGE: 0 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.
10-NAME OF FATHER, John H. Kohl
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md
12-MAIDEN NAME OF MOTHER, Eva D. Burger
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) John H. Kohl
(Address) 2940 E. Monument

15- Filed FEB 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2/28/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 26 1924 to Feb 28 1924

that I last saw h.. alive on Feb 28 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions - Extraction

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schaefer M. D

Feb 28 1924 (Address) 701 Hollywood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Glenmore Pmn — DATE OF BURIAL: 2/29 1924

20-UNDERTAKER: Philip Henry — ADDRESS 2016 Orleans

should be carefully supplied. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84290

CERTIFICATE OF DEATH.

181-001

D 84290

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 869 Hallen ave ST., 13 WARD)

2-FULL NAME Mollie Smith

(a) RESIDENCE No. 3412 Beach ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Divorced.

5a If ~~married, widowed, or~~ divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50		7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Matron at
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel Chatsell
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant George F. Foote
(Address) 1709 E 20th St City

15 Filed FEB 28 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas
(accidental) (Illuminating)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) defective gas stove tube,
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

Feb. 28, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cem't — DATE OF BURIAL Feb 28 24

20 UNDERTAKER Lilye Zeiler — ADDRESS 403 So Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF PROCESS TION is very important. See instructions on back of certificate.

Spec.-12-23-21—E.B.R.S.—400 Bks.

Dr. Geddes — 321 E 25th

D 84291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D 84291
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1339 Fallsy St — St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Louisa Hampton

(a) Residence No. 1339 Fallsy St — St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 11 1879

7-AGE	If LESS than 1 day,
45 yrs. mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Francis M. Hampton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Laura J. Grenade

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-

(Informant) Edwd. M. Hampton

(Address) 4919 Emmorton Rd

FEB 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 26 1924

17- I HEREBY CERTIFY, That I attended deceased from 10/10/22, 19..., to 2/26/24, 19..., that I last saw h.. alive on 2/26/24, 19..., and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Uterus Carcinoma

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Wm Geddes, M. D.

2/27/24 19 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, No Glend | DATE OF BURIAL, Feb 29, 1924

20-UNDERTAKER, Wm Cook | ADDRESS 502 E Balto St

Should be carefully supervised. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84292
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

28 D 84292
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 811 Plowman ST., 3 WARD)

2-FULL NAME Edwin Louis Poole

(a) RESIDENCE NO. White Marsh, Balto. Co., Md. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 66 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Hewitt

6 DATE OF BIRTH (month, day, and year) Mar. 20, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Manager - J. Frank
(c) Name of employer Eline Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin R. Poole

11 BIRTHPLACE OF FATHER (city or town) Charlestown
(State or country) West Va.

12 MAIDEN NAME OF MOTHER Susan Eager

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Donald F. Poole
(Address) White Marsh, Balto. Co. Md.

FEB 28 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) yrs. 25 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blacks, M. D.
(Coroner)
Feb 27 1924 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery
DATE OF BURIAL 2/28 1924

20 UNDERTAKER Henry W. Mears & Son
ADDRESS 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/84293

CERTIFICATE OF DEATH.

X 3/

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S.M.H.#1 St., Baltimore Ward 12.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Anderson.

(a) RESIDENCE No. U.S.M. Hospital No 1. Baltimore, Md. St., Ward Not Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? Un known yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26 years.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant.

(c) Name of employer Un known

9 BIRTHPLACE (city or town) (State or country) Alaska

PARENTS

10 NAME OF FATHER Un known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un Known

12 MAIDEN NAME OF MOTHER Un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un known

14 Informant Self.

(Address)

15 Filed FEB 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26 1924.

17

I HEREBY CERTIFY, That I attended deceased from December 19, 1923, to February 26, 1924, that I last saw h... alive on February 26, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Un known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Un known

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) M. F. Foster, M. D.

Feb 27, 19 (Address) U.S. Marine Hospital Surgeon, U.S.P.H.S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 2/27 1924

20 UNDERTAKER Jos L. Linson & Bro

ADDRESS 1127 E. Baltimore St

mation should be carefully supplied. Age ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84294

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 Sarah ann St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Cornish

(Residence in Baltimore: No. 819 Sarah ann St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: C

5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: Mar 6 (Month) (Day) 1874 (Year)

7-AGE: 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Neal Cornish

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Catherine Howard

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Jones

(Address) 819 Sarah ann St.

15- Filed FEB 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 25 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H K Jarvis M. D. (Coroner.)

2-27 1924 (Address) 117 W. Saratoga

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Laurel Cemetery Feb 28 1924

20-UNDERTAKER. ADDRESS
Wm. P. G. Ellis 725 Ashland Ave

N. B.—Every item must be properly classified. Exact statements of occupation, cause of death, etc., may be required. Before filling out this certificate, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of occupation, cause of death, etc., may be required. Before filling out this certificate, is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 84295

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 84295

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 W. Mulberry ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John A. Skabiskay

(a) RESIDENCE NO. 1418 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? 23 yrs. 1 mos. 26 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Diana K. Skabiskay

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Helen Skabiskay 1418 W. Mulberry St.

FEB 28 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 19 24

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24 19 24 to Feb. 26 19 24

that I last saw him alive on Feb 26 19 24

and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 7 ds. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank A. Bressler, M. D.

2/27 19 24 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	2/29 19 24
20 UNDERTAKER: Charles B. Kuchaucka	ADDRESS: 632 S. Paca St.

Information should be carefully supplied. AGE ... at it may be properly classified. Exact statement of OCCUPA... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... s on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84296

CERTIFICATE OF DEATH.

129 D 84296

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Dolphin ST.: 17 WARD)

2-FULL NAME George W Fletcher

(a) RESIDENCE. No. 531 Dolphin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah B Fletcher

6 DATE OF BIRTH (month, day, and year) unknown 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work China packer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Frederick Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Sara B Fletcher
(Address) 531 Dolphin St.

Filed FEB 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24 19 24

17 I HEREBY CERTIFY, That I attended deceased from 2-13 19 24, to 2-24 19 24, that I last saw him alive on 2/24 19 24, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Int Nephritis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Insuff (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical exam

(Signed) Daniel Miller, M. D.

, 19 (Address) 1066 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2/28 19 24
20 UNDERTAKER	ADDRESS
Samuel J Wrigley	1 Biddle

mation should be carefully supplied. Exact statement of occupa-
it may be properly classified. Exact statement of
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on ba

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84297

CERTIFICATE OF DEATH.

31 D 84297

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1649 E Monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilia Baptiste

(a) RESIDENCE NO. 1649 E Monument ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Baptiste

6 DATE OF BIRTH (month, day, and year): May 22 1899

7 AGE: Years 24 Months 9 Days 3 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Eugene Deshields

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Marie Pinkney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Marie Henson 1649 E Monument St

15 Filed FEB 28 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-25 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1927, to Feby 25, 1924, that I last saw her alive on Feby 25, 1924, and that death occurred, on the date stated above, at 5-P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 23 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm A Sage, M. D.

2/27 1924 (Address) 1709 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. DATE OF BURIAL 2-29 1924

20 UNDERTAKER: Saml J Hunsley ADDRESS: Dr Balto

Exact statement of OCCUPA... may be properly classified. ...n back of certificates.

...mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

D 84298 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-901 D 84298

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2013 Oak ST., 17 WARD)

2-FULL NAME George W. Pendleton

(a) RESIDENCE NO. 2013 Oak ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie E. C. Pendleton

6 DATE OF BIRTH (month, day, and year) Mch 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) King George Co Va

PARENTS
10 NAME OF FATHER Wm Dan
11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama
12 MAIDEN NAME OF MOTHER Mary Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Carrie E. C. Pendleton
(Address) 2013 Oak St

15 Filed FEB 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1924 to Feb 25 1924
that I last saw him alive on Feb 25 1924
and that death occurred, on the date stated above, at 11 P M.

The CAUSE OF DEATH was as follows:
Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. S. Columbus M D.
(Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL 2/29 1924

UNDERTAKER Samuel D Hawsley ADDRESS 1738 Bolton

Exact statement of occupation should be carefully supplied. Non-specific terms may be properly classified. CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-802 D 84299

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 Druid Hill Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Mae Epps

(a) RESIDENCE NO. 1427 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 19 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jack Epps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Edna Coles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address) Edna Epps 1427 Druid Hill Ave

15 Filed FEB 28 1924 19

ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24 1924, to Feb. 26 1924, that I last saw h[illegible] alive on Feb. 26 1924, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Premature 6½ mos.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Handley, M. D.

2/28 1924 (Address) 2805 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL 2/28 1924

20 UNDERTAKER: Samuel Handley ADDRESS N Bradle

N. B.—[illegible] should be carefully supplied. AGE [illegible] mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84300

D 84300
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 W Mulberry St. ST.; 4 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Allen

(a) RESIDENCE. NO. 731 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs L. Davis
(Address) 731 Mulberry St

15 Filed FEB 28 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28. 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct-1922 19 . to Feb-27 . 1924
that I last saw her alive on Feb-26 . 1924
and that death occurred, on the date stated above, at 2-10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis. Mitral Insufficiency
+ Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. K. Brady M. D.

2-28 1924 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Scottsburg Va	2/29 1924
20 UNDERTAKER Samuel G. Wamsley	ADDRESS Bel Air

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Allen

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 D 84300

CERTIFICATE OF DEATH.

D 84300
1-PLACE OF DEATH

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 731 W Mulberry St. ST.; 4 WARD)

2-FULL NAME Martha Allen

(a) RESIDENCE. NO. 731 W. Mulberry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs L. Davis
(Address) 731 Mulberry St

15 Filed FEB 28 1924 Registrar

ROBERT R. KRAUTER
Social Service Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28- 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct-1922 19 . to Feb-27 . 1924
that I last saw her alive on Feb-26 . 1924
and that death occurred, on the date stated above, at 2-10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis. Mitral Insufficiency
+ Arteri Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. H. Cooley, M. D.

2-28-1924 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scottsberg Va

DATE OF BURIAL 2/29 1924

20 UNDERTAKER Samuel F. Stansbury

ADDRESS 17 N Eutaw

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84301

CERTIFICATE OF DEATH.

3 1 D 84301

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 767 S. Robinson St. ST., 1 WARD)

2-FULL NAME William L. Lieben.

(a) RESIDENCE NO. 767 S. Robinson ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Lieben.

6 DATE OF BIRTH (month, day, and year) Aug. 24-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Dry Docks.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Ambrose Lieben.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Anna McCorkell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna M. Lieben

(Address) 767 S. Robinson St.

15 FEB 28 1924 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to Feb. 26 1924

that I last saw h... alive on ....., 19....,

and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Tuberculous Laryngitis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test ~~confirmed~~ diagnosis?

(Signed) Frederick D. Zeiler, M. D.

2/26, 19 (Address) 719 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Feb. 29 19 24

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84302

CERTIFICATE OF DEATH.

94-001 D 84302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 320 S. Calhoun St. (Ward) 18

2-FULL NAME Robert A. Hurley

(a) RESIDENCE NO. 320 S. Calhoun St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 30 1923

7 AGE — Years: — Months: 2 Days: 27. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: John C. Hurley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Margie Waidner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John Hurley

(Address) 320 S Calhoun St

FEB 28 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1924 to Feb 26 1924, that I last saw h[illegible] alive on Feb 26 1924, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis.

(duration) 5 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 1535 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: Feb 29 19

20 UNDERTAKER: John J Fields — ADDRESS 700 W Lombard

Burial Permit Clerk.

N. B.—Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84303

CERTIFICATE OF DEATH.

90 D 84303

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Gilmor St. ST., 19 WARD)

2-FULL NAME Louise M. Bauer

(a) RESIDENCE No. 225 N. Gilmor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 12, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Francis Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Bauer

(Address) 225 N Gilmor

15 Filed ROBERT R. KRAUTER, Registrar

FEB 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1923 to Feb. 27, 1924.

that I last saw her alive on Feb 27, 1924

and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of "

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coale M. D.

2/28 24 , 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 29 1924
20 UNDERTAKER	ADDRESS
Wm J Fields	1200 W Fayette

Exact statement of occupation should be carefully supplied. Avoid use of terms that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

16962 23

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84304

CERTIFICATE OF DEATH.

49 D 84304

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Mollie Wilson

(a) RESIDENCE No. 426 N. Pine St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wilson

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. n/

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Randolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed FEB 29 1924 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924, to Feb 24, 1924.

that I last saw her alive on Feb 24, 1924,

and that death occurred, on the date stated above, at 3 30 A.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Uterus

Hypertension

Myocardial Insuff.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? yes Date of 2/25/24

there an autopsy? yes.

What test confirmed diagnosis? Microscopic & autopsy

(Signed) Geo. H. Gardner, M.D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 2 1924

20 UNDERTAKER R. L. Grass. ADDRESS 1405 McElderry

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

FILMED

Spec.—1-10-21—M&T—1500 Blks.

16952 D 84305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146

REGISTERED NO. D 84305

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Maggie Bodie

(a) RESIDENCE NO. 1121 Thompson ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Boddie

6 DATE OF BIRTH (month, day, and year) — 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Phillips

11 BIRTHPLACE OF FATHER (city or town) South (State or country) Carolina

12 MAIDEN NAME OF MOTHER Nellie Haynes

13 BIRTHPLACE OF MOTHER (city or town) South (State or country) Carolina

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 FEB 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1924, to Feb 25, 1924, that I last saw her alive on Feb 25, 1924, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Puerperal infection.
General peritonitis.
(Following normal labor)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary embolus (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) E E Duncan, M. D.
2/27 1924 (Address) Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 2-28-1924

20 UNDERTAKER E E Gross — ADDRESS 425 Mc Elderry

Information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S·A·E

Spec—2-23-21—E.R.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84306

CERTIFICATE OF DEATH.

129 D 84306

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 W. Fayette St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverda Fullerton Schumacher

(a) Residence No. 1427 W. Fayette St., 19 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 70 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Edw. R. Schumacher

6-DATE OF BIRTH (month, day and year): ? ? About 1849

7-AGE: About 75 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: Thomas D. Fullerton

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Abingdon Harford Co. Md.

12-MAIDEN NAME OF MOTHER: Cornelia Berryman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Maryland.

14- (Informant): Miss Isabella B. Fullerton

(Address): 1427 W Fayette St. (Sister)

15- FEB 28 1924 ROBERT P. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 23 to Feb 26, 24, that I last saw h.. alive on Feb 26, 19 24, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lucien A Corder M. D.

, 19 (Address) 150 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL, Feb 28, 1924

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statements of occupation. Read instructions on back of certificates.

D 84307. HEALTH DEPARTMENT—CITY OF BALTIMORE D 84307.

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1227 Linden Ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances H. Walter

(Residence in Baltimore: No. 1227 Linden Ave St.; yrs., 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, ~~Married~~ Widowed, or ~~Divorced~~. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. March (Month) 21 (Day) 1852 (Year)

7-AGE. about 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country) Missouri

PARENTS.

10-NAME OF FATHER. John M. Hall

11-BIRTHPLACE OF FATHER. (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER. Elizabeth A. Crawford

13-BIRTHPLACE OF MOTHER. (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Hall

(Address) 2124 W. Royal Ave

15- FEB 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 27th, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

adenopalenosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis.

(Duration) 3 yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

192 (Address)

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem.	Feb 29, 1924
20-UNDERTAKER,	ADDRESS
Henry W. Jenkins & Son	Orchard & McCulloh Sts

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. It is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84308

CERTIFICATE OF DEATH.

38 D 84308

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Wood Burch

(a) RESIDENCE No. 100 B Ridgewood Road ST. Roland Pk WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernadette Combs

6 DATE OF BIRTH (month, day, and year) April 21, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Metal Stripping

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Burch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant L Hall

(Address) 2124 Nt Royal Terrace

15 Filed FEB 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1924, to Feb. 27, 1924, that I last saw him alive on Feb. 27, 1924 and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Luetic Endarteritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann on Spinal Fluid

(Signed) Jay Martin, M. D.

2/27, 1924 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 28 1924
20 UNDERTAKER Henry D Jenkins Sons	ADDRESS Edmondson Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84309

D 84309

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. On Way to Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace F. Barton

(Residence in Baltimore: No. 532 N. Chester St.; yrs., mos., ds.)

50

PERSONAL AND STATISTICAL PARTICULARS.

4-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July (Month) 15 (Day) 1867 (Year)

7-AGE. 59 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).....

09

9-BIRTHPLACE. (State or Country). New York

PARENTS.

10-NAME OF FATHER. Henry Barton

11-BIRTHPLACE OF FATHER. (State or Country). England

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER. (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Barton

(Address) 532 N. Chester

15- Filed FEB 28 1924 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 26 (Day) 24 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Dont Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) " " "

(Duration) yrs. mos. ds.

(Signed) T. T. Engle M. D. (Coroner)

2-27 192 4 (Address) 117 W. Saratoga St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. Feb. 29 1924

20-UNDERTAKER. Jos. J. Aberg & Son ADDRESS 1564 N. Luzerne

N. B. ~~Either~~ CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84310

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 E. Williamson St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John E. Dunn

(a) Residence No. 19 E. Williamson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 26. 1924

7-AGE. ....yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or. ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9-BIRTHPLACE (city or town) (State or Country). Balto md

PARENTS.

10-NAME OF FATHER, John W. Dunn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Catherine L. Long

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) John W. Dunn
(Address) 19 E Williamson St

15- Filed FEB 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 27. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 24 1924 to Feb 27, 1924

that I last saw him alive on Feb 27, 1924

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

Feb 28 1924 (Address) 1640 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemetery — DATE OF BURIAL, Feb. 29, 1924

20-UNDERTAKER, Margaret E. Flynn — ADDRESS 1422 Light St

In plain terms, so that it may be properly classified. Exact statement of occupation is required. See instructions on back of certificate.

Spec.—1-30-21—M&T—1500 Bks.

D 84311

167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84311

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 10 WARD)

2-FULL NAME Josiah Hughes

(a) RESIDENCE NO. 808 N. Spring St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 05, 1912

7 AGE. Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
11	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Josiah Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ada Whittington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 FEB 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1923 to Feb 26, 1924.

that I last saw him alive on Feb 26, 1924.

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis (rheumatic)

(Mitral Insufficiency)

(dutation) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edmund H. Kesper, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge cemetery

DATE OF BURIAL 27th Feb 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Exact statement of occupa... it may be properly classified. ... on back of certificates.

CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back ...

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 84312

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 228 S. Chester St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary E. Connelly

(a) Residence No... 228 S. Chester St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W hite

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Coleman Connelly

6-DATE OF BIRTH (month, day and year) Jan 31 1841 85

7-AGE, 58 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thos Walsh

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-

(Informant) Coleman Connelly husband

(Address) 228 S. Chester St.

FEB 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/24/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. (illegible), 19 23, to Feb 24, 19 24

that I last saw h[illegible] alive on Feb 24, 19 24

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Samuel E. Finkelstein, M. D.

, 1924 (Address) 922 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, 2/29/, 19 24

20-UNDERTAKER, J. J. Moran — ADDRESS 3900 E. Baltimore

Filled. Exact statements of occupations are necessary. Please write in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84313

CERTIFICATE OF DEATH.

57 D 84313

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 N Clinton St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary Fisher

(a) Residence No... 124 N. Clinton St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, ~~or divorced~~ HUSBAND of ~~(or)~~ WIFE of Chas A Fisher

6-DATE OF BIRTH (month, day and year) Jan 8-1863

7-AGE. 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer..... 0

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Caufield

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Chas F. Fisher

(Address) 1005 Bonaparte St

15- FEB 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 2 1924 to Feb 26 1924

that I last saw him alive on Feb 26 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Both legs amputated Diabetes Gangrene

½ yrs. mos. ds. (Duration)

CONTRIBUTORY (Secondary) Diabetes Coma

2 yrs. mos. ds. (Duration)

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Autopsy

(Signed) W. H. McClanahan M. D.

Feb 27 1924 (Address) 3508 Pont Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Redeemer Bem

DATE OF BURIAL, 2/29 1924

20-UNDERTAKER. J. J. Moran

ADDRESS 3 and E Balto St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84314

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Yarborough

(a) RESIDENCE NO. 2011 Oak street ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. 24 mos. ds.

Virginia

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Yarborough

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 63; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer): House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER Nehemiah Muse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Caroline Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Municipal Vital Records. ROBERT R. KRAUTER,

15 Filed ..... 19 ..... Burial Permit Clerk.

FEB 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 3 1924 to Feb. 26 1924.

that I last saw her alive on 2/26 1924,

and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of Abdominal Viscera, primary in Gall-bladder & metastases to liver, stomach, Intestine

(duration) Uncertain mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 2/12-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John M. Edmonds M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington, D.C. Union State

DATE OF BURIAL: Feb 28. 1924

20 UNDERTAKER: Mrs R A Elliott

ADDRESS 1725- Ashland Av

malion should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 84315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3723 Leaverton St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen A Simmons

(a) Residence No. 3723 Leaverton St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Simmons

6-DATE OF BIRTH (month, day and year) 8/1/1847

7-AGE. 77 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Copper Works

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Stephen Simmons

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Katharine Stuffard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14-(Informant) Mrs Louisa A Simmons

(Address) 3723 Leaverton

15-Robert F. Harrison,

2 8 1924 ...ial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2/27/1924

17-I HEREBY CERTIFY, That I attended deceased from Feb 19 1924 to Feb 27 1924

that I last saw h... alive on Feb 27 1924

and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteris Sclerosis

Chron Int Nephritis (Duration) unknown. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Dr Jones.

(Signed) Chas Lentz, M. D.

2-28-1924 (Address) 2601 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel Cem

DATE OF BURIAL, 3-1-, 1924

20-UNDERTAKER, John Ellerich

ADDRESS 208 E Eager

Arteris-Sclerosis & Chron Int Nephritis About 5 Yrs.

In accordance with the law, all the information required must be given so far as known. Exact statement of occupations is required. Certificate must be filled in plain terms, so that it may be properly classified. Physicians are requested to write plainly, and to state cause of death in accordance with instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84316

CERTIFICATE OF DEATH.

90 D 84316

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1444 Boyle St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdalene Rice

(a) Residence No. 1444 Boyle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Rice

6-DATE OF BIRTH (month, day and year) Mar. 3 1843

7-AGE. 80 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER. John Kraft

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Mrs. Henry C. Craig (Address) 1444 Royle St.

15- Filed 2 8 1924 Robert L. Harris, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby 28/24

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1923 to Feby 28 1924 that I last saw her alive on Feby 28 1924 and that death occurred, on the date stated above, at 6 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Dis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age

(Duration) / yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Darlington M. D

, 19 (Address) 102 E. Fort Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cemetery

DATE OF BURIAL. 3/1, 1924

20-UNDERTAKER. J. Few McCully

ADDRESS 130 E. Fort Ave

in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84317

CERTIFICATE OF DEATH.

11 D 84317

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Hollins St ST. 18 WARD)

2-FULL NAME James B. Frasier

(a) RESIDENCE. No. 1132 Hollins St ST., 18 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Frasier

6 DATE OF BIRTH (month, day, and year) Sept 16 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) Art dept.

(c) Name of employer Balto. American

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Owen Frasier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Holmes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Margaret Gilbert
(Address) 2.. f. Clinton St.

15 Filed FEB 28 1924 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to Feb 26, 1924, that I last saw him alive on Feb 26, 1924, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L. Hooper, M. D.

2/28, 1924 (Address) 346 S. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Feb 29 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 W Fayette

Burial Permit Clerk.

mation sought on certificate, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

96 N. Fulton.

D 84318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84318

CERTIFICATE OF DEATH. 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3025 Presstman St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes L. Reed

(a) Residence No. 3025 Prest-man St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 16 1880

7-AGE, 43 yrs. 2 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Cincinnati Ohio

PARENTS.

10-NAME OF FATHER, Edward L Reed

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Agnes Watts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ohio

14- (Informant) Lewis H. Reed

(Address) 3025 Prestman St.

15- Feb 23 1924 Robert F. Harrison Registrar.

EB 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov - 1 - 1923, to Feb 27 1924

that I last saw h— alive on Feb - 27 -, 1924

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

of Heart.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Malcolm W Short M. D.

Feb 28. 1924 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn DATE OF BURIAL, March 1924

20-UNDERTAKER, Wm Cook ADDRESS 574 Est. Ave.

In plain terms, so that it may be properly classified. Exact statement of cause of death. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84319

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 Sharp ST., 13 WARD)

2-FULL NAME Mrs Anna M Krieg

(a) RESIDENCE NO. 1033 S Sharp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Albert A Krieg

6 DATE OF BIRTH (month, day, and year): Aug 30, 1845

7 AGE — Years: 78 — Months: 5 — Days: 27 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Schmaltz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs W Grabenhorst

(Address): Parkville

15 Filed FEB 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924, to Feb 27, 1924,

that I last saw h.. alive on Feb 26, 1924,

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

from Unknown (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J F Cushman, M. D.

Feb 27 1924 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Lot — DATE OF BURIAL: Mar 3 1924

20 UNDERTAKER: Wm. Carroll Sons & Edmondson — ADDRESS

mation should be carefully supplied, so that it may be properly classified. Exact statement of occupation and CAUSE OF DEATH in plain terms

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84320

D 84320

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 Myrtle Ave.) (WARD) 17

2-FULL NAME J. Steward Davis, Jr.

(c) RESIDENCE NO. 1047 Myrtle Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER J. Steward Davis

11 BIRTHPLACE OF FATHER (city or town) Pa.

(State or country)

12 MAIDEN NAME OF MOTHER Blanche E. Moore

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant J. Steward Davis

(Address) 1047 Myrtle Ave.

15 2 8 1924 Robert P. Garrison, Registrar

Chief Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1924, to Feb. 27, 1924,

that I last saw h/m alive on Feb. 27, 1924,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) W. J. Carr Jr., M. D.

(Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 29 1924

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84321

CERTIFICATE OF DEATH. 11-001

D 84321

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Robinson ST.: 6 WARD)

2-FULL NAME Jeannette E. Miller

(a) RESIDENCE. (No. 310 N. Robinson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~Life~~ 11 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) 2/23/1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown Md

PARENTS

10 NAME OF FATHER Carl L Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rebecca Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown Md

14 Informant Mr Carl L Miller (Address) 310 N Robinson St

15 Filed 3 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to Feb 27, 1924, that I last saw ... alive on Feb 27, 1924, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

La Grippe — Influenza

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Fred ... M. D.

2-28-24 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Lutheran Cemetery	2/29 1924

20 UNDERTAKER Albert L Nitz jr ADDRESS 1606 N Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84322

CERTIFICATE OF DEATH.

D 84322

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lakeview Hospital ST., 15 WARD)

2-FULL NAME William Bradford

(a) RESIDENCE NO. 1738 N. Payson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James Bradford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Rachel Lawson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Chas H. Hummer
(Address) 1840 W. Mulberry st

15 Filed ... 192... Robert P. Harrison, Registrar

B 28 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cer. Dementia Paralytica

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema,

(duration) yrs. mos. 1 ds.

(Signed) D. J. Hennessy, M. D.
(Coroner)

Feb. 28, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Mount Cem

DATE OF BURIAL Feby 29 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. Northern

CAUSE OF DEATH must be plainly written. See instructions on back of certificate.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84323

CERTIFICATE OF DEATH.

46 D 84323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2810 Clifton ave ST. 15 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie F Tample

(a) RESIDENCE. No. 2810 Clifton ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jobst B Tample

6 DATE OF BIRTH (month, day, and year) Oct 10 79

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Binder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gustav C Tample
(Address) 2804 Riggs ave

15 Filed , 19 Robert F. Harrison, Registrar

B 2 8 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17

I HEREBY CERTIFY, That I attended deceased from July, 1923, to Feb. 27, 1924, that I last saw h[illegible] alive on Feb. 27, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri with metastasis. (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis. (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1922.

Was there an autopsy? no.

What test confirmed diagnosis? Operative findings

(Signed) Wm Mitchell M. D.

Feb 28 1924 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 29 1924
20 UNDERTAKER W. M. Routson	ADDRESS 2238 W North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of conditions on back of certificates. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84324

CERTIFICATE OF DEATH.

D 84324

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2238 W North ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ella V Snyder

(a) Residence No. 2238 W North ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick T

6-DATE OF BIRTH (month, day and year) Aug 7, 1857

7-AGE.	If LESS than 1 day,
67 yrs. 6 mos. 19 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home 1
(b) General nature of industry, business, or establishment in which employed (or employer)..... work 03
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Pa.
(State or Country).

PARENTS.

10-NAME OF FATHER, Anna Rice

11-BIRTHPLACE OF FATHER (city or town)..... Pa.
(State or Country).

12-MAIDEN NAME OF MOTHER, Heintzelman

13-BIRTHPLACE OF MOTHER (city or town)..... Pa.
(State or Country).

11- Informant) W M Rowton

(Address) 2238 W North ave

B 28 1924 Robert F. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 26/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 21, 1924, to Feb 26, 1924, that I last saw h[illegible] alive on Feb 26, 1924, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows:

Leukemia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual examination

(Signed) Fred B Jewett M. D.

Feb 27 1924 (Address) 2676 Brom ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Chambersburg Pa.	Feb 29... 1924
20-UNDERTAKER.	ADDRESS
W M Rowton	2238 W North

Should be entered in plain terms, so that it may be properly classified. Exact statement of occupation is required. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84325

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 N. Broadway ST., 7 WARD)

2-FULL NAME Jane Ritchie Wilson Tydings

(a) RESIDENCE NO. 806 N. Broadway ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph S. Tydings

6 DATE OF BIRTH (month, day, and year) June 14, 1861,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Falls.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Matilda Ritchie

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Miss Jennie Tydings,
(Address) 806 N. Broadway

Filed FEB 28 1924, 19 Robert L. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1921, to Feb. 26, 1924,

that I last saw h[illegible] alive on Feb 9, 1924,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

Death was practically instantaneous
(A few minutes.) (duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Hypertension.
(duration) 3 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Mrs J Hatton, M. D.

Feb 28, 1924 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Feb. 29, 1924
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

mation should be carefully supplied. Exact statement
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-23 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84326

CERTIFICATE OF DEATH.

74 D 84326

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 Presstman ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Johnson

(a) RESIDENCE NO. 578 Presstman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Johnson

6 DATE OF BIRTH (month, day and year) — — 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Wm Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Charles Johnson
(Address) 523 Bolton St

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

FEB 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20th, 1924 to Feb. 25th, 1924, that I last saw h[illegible] alive on Feb. 25th, 1924, and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows:

Hemoplegia

duration 14 days

CONTRIBUTORY (Secondary) Arteriosclerosis duration 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

2/26, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Mar. 1, 1924

20 UNDERTAKER Woodyard & Dennis — ADDRESS 1005 Pennsylvania

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84327.

CERTIFICATE OF DEATH.

D 84327.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1713 Presbury St ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Hawkins

(Residence in Baltimore: No. 1713 Presbury St

S. 1 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Infant

6-DATE OF BIRTH. June 22, 1923
(Month) (Day) (Year)

7-AGE. 1 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). City

PARENTS.

10-NAME OF FATHER. Louis Hawkins

11-BIRTHPLACE OF FATHER (State or Country). City

12-MAIDEN NAME OF MOTHER. Lavada Tasson

13-BIRTHPLACE OF MOTHER (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Hawkins

(Address) 1713 Presbury St

15- Robert J. Morrison, ..., 191.....
Registrar.

B 2 81924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 27, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. 0 mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Feb 28, 1924 (Address) 2852 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Zion Cemetery	Feb 29th 1924
20-UNDERTAKER	ADDRESS
Emma E. Wright	1364 N Carey St

Every death must be reported promptly to the Health Department, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84328

1-PLACE OF DEATH

City of BALTIMORE: (No. 3907 Liberty Heights Ave. Ward) 12

Registered No.....

2-FULL NAME Augustus Hartman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 3907 Liberty Heights Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Hartman

6-DATE OF BIRTH (month, day and year) Sept 9-1845

7-AGE 76 yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. —

(b) General nature of industry, business, or establishment in which employed (or employer). Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, John Hartman

11-BIRTHPLACE OF FATHER (city or town) Penna (State or Country),

12-MAIDEN NAME OF MOTHER, Eve Miller

13-BIRTHPLACE OF MOTHER (city or town) Penna (State or Country).

11- (Informant) Herbert Hartman

(Address) 3907 Liberty Heights Ave

15- Robert P. Harrison
Registrar.

B 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-27-1924

17- I HEREBY CERTIFY, That I attended deceased from 2-21, 1924, to 2-27, 1924, that I last saw him alive on 2-27, 1924, and that death occurred, on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Austin F. Robinson M. D

2-28, 1924 (Address) 1307 Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loud Rudgeon — DATE OF BURIAL. Feb 29 1924

20-UNDERTAKER W. H. Buchmueller — ADDRESS North Ave

In plain terms, so that it may be properly classified. Exact statements of cause of death required. See instructions on back of certificates.

D 84329 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead 70 181-005 Registered No. C.....

City of BALTIMORE: (No. St. Agnes Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Hardy

(Residence in Baltimore: No. 429 Rosedale Terrace St.; yrs. Life mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. March 11, 1888 (Month) (Day) (Year)

7-AGE. 35 yrs. 11 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance
(b) General nature of industry, business, or establishment in which employed (or employer): Broker 880

9-BIRTHPLACE, (State or Country). Balto. City.

PARENTS.

10-NAME OF FATHER. William Hardy

11-BIRTHPLACE OF FATHER. (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Mary Hussy

13-BIRTHPLACE OF MOTHER. (State or Country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie M. Hardy

(Address) 429 Rosedale Terrace

15- Robert P. Griffith, M.D. Registrar.

2 8 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 27, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Gas due to Accident

(Duration) ..... yrs. Instant mos. ..... ds.

CONTRIBUTORY (Secondary) Letting Automobile running - Garage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Lenehan M. D. (Coroner.)

Feb 27 1924 (Address) 701 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel DATE OF BURIAL. Mar 1 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 E Fayette Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each certificate is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84330

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84330

CERTIFICATE OF DEATH.

74-000

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Fine

(a) RESIDENCE NO. 104 S Eden St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? 20 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Fine

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Asm. Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Israel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Robert F. Harrison, Registrar

FEB 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17 I HEREBY CERTIFY, That I attended deceased from ..... 1924 to Feb 28 1924.

that I last saw her alive on Feb 28 1924,

and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

[illegible]

(duration) ... yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage (?)

(duration) ... yrs. mos. 15 min ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Mt Carmel.

DATE OF BURIAL Feb 28 1924

20 UNDERTAKER S Levinson Bro

ADDRESS 1278 Balto St

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84331 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84331

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 W. Hoffman St., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Mathews

(a) RESIDENCE No. 610 W. Hoffman St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Mathews

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gas & El. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Henrietta Mathews
(Address) 610 Hoffman St.

15 FEB 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CAUSE OF DEATH: This information is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Feb. 28, 1924 (Address) 2801 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2 29 1924

20 UNDERTAKER David Easton

ADDRESS 916 Eutaw

D 84332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84332

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 800 Pierce St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W White

(Residence in Baltimore: No. 800 Pierce St St.; yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Mard

6-DATE OF BIRTH: Dont Know (Month) (Day) 187- (Year)

7-AGE: 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE (State or Country): Md

PARENTS

10-NAME OF FATHER: Robt White

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Cathrin Parker

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary White

(Address) 800 Pierce St

FEB 29 1924 (Date) 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb (Month) 25 (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~Inquest, autopsy or~~ Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) Dont Know yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Grumbrecht M. D. (Coroner.)

2-29 192 4 (Address) 117 W Saratoga St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn DATE OF BURIAL: Feb 29 19 24

20-UNDERTAKER: Gorlin H. Trader ADDRESS 142 Custer St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84333

CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH Church Home & Inf.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1600 Broadway. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr George C. Miller

(a) RESIDENCE NO. 650 N Carey St. ST. Baltimore Md.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Lynch

6 DATE OF BIRTH (month, day, and year) American

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales-manager

(b) General nature of industry, business, or establishment in which employed (or employer) Autographic Register Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn.

PARENTS

10 NAME OF FATHER Theodore T. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Fannie A. Bugbee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stafford Conn.

14 Informant John M. Martin
(Address) Lakewood N. J.

15 Filed 19 FEB 29 1924

HOBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1924, to Feb 28, 1924, that I last saw him alive on Feb 28, 1924, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH was as follows:

Encephalitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 28 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Cayetano Tancelleon, M. D.

, 19 (Address) Church Home Inf Dep

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Windsor Locks, Conn.	May 1 1924
20 UNDERTAKER Henry W. Maus & Son	ADDRESS 805 N. Calvert St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84334

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Linden ave ST., 13 WARD)

2-FULL NAME Nechama Fraidin all so known as mollie - millie x mollie

(a) RESIDENCE NO. 2321 Linden ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jacob Fraidin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 31
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 Eutaw st

FEB 29 1924 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febr. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1923, to Feb. 28, 1924, that I last saw h[illegible] alive on Feb. 28, 1924, and that death occurred, on the date stated above, at 8[illegible]45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Gall-Bladder

(duration) ..... yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Yes Date of Jan 26, 1924

Was there an autopsy?

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Samuel Wolman M. D.

, 19 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Rosedale	2/29 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 Eutaw st

mation should be correctly supplied. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that i
TION is very important. See instructions o
ons on back of certificates.

Spec—11-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84335

CERTIFICATE OF DEATH.

101-001 D 84335

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1929 Jefferson St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eldon Worthington

(a) Residence No. 1929 Jefferson St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. A Worthington

6-DATE OF BIRTH (month, day and year) July 2 1848

7-AGE, 75 yrs. 7 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER Elias Brinsfield

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) John B. Wallace

(Address) 2610 E. Baltimore

15- Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 27/1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to Feb 27, 1924, that I last saw h.. w.. alive on Feb 27, 1924, and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of.....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Ralph Stigt M. D.

, 19 (Address) 26 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Ed Lawn — DATE OF BURIAL, 2/29/24

20-UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson ave

In plain terms, so that it may be properly classified. Exact statement of cause required. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84336

CERTIFICATE OF DEATH.

74-002 D 84336

1. PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3403 Lyndale Road ST., 26 WARD)

2. FULL NAME Catherine Hulseman

(a) RESIDENCE No. 3403 Lyndale Road ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Claymore Hulseman

6 DATE OF BIRTH (month, day, and year) Feb. 14 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	59		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 87

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER John Driscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Claymore Hulseman
(Address) 3403 Lyndale Rd

FEB 29 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 13th, 1924, to Feb 28th, 1924, that I last saw h[illegible] alive on Feb 28th, 1924 and that death occurred, on the date stated above, at 5-55 P m.

The CAUSE OF DEATH* was as follows:

Multiple Genitis

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cerebral Embolis

(duration) ..... yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual methods

(Signed) H. D. Thompson, M. D.

Feb 29 1924 (Address) 1424 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem — DATE OF BURIAL Mch 3 1924

20 UNDERTAKER Chas. E. Franck — ADDRESS 501 Madison Ave

mation should be carefully supplied. Exact statement of occupa
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84337

84337

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 N. Caroline ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria A Roberts

(a) RESIDENCE. No. 1522 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 7 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Roberts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Eliza Mottu

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Wood
(Address) 1522 N. Caroline St

15 Filed . 19 ROBERT R. KRAUTER Registrar
FEB 29 1924 Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 27 1924, to Feb 27, 1924, that I last saw her alive on Feb 27, 1924, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis, Indigestion & Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Indigestion

(duration) several yrs. mos. ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. H. Carman, M. D.

2-28-1924 (Address) 1701 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Mch 1 1924

20 UNDERTAKER Chas E Franck & Madison — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84338 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 D 84338

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 N. Fulton Av ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia S. Wattenscheidt

(a) RESIDENCE. NO. 542 N. Fulton Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Ewald Wattenscheidt

6 DATE OF BIRTH (month, day, and year) Feb. 28/1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —— Ohd

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Philip Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ewald Wattenscheidt Jr
(Address) 542 N. Fulton Av

15 FEB 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1924

17 I HEREBY CERTIFY, That I attended, deceased frum Feb. 11, 1924, to Feb 25th, 1924, that I last saw h er alive on Feb 25th 12.15 pm, 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Senility. Myocardial de-
compensation.
Myocardial decompensation
about a week — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical —

(Signed) A Corbus Streett, M. D.

, 19 (Address) 1121 Park Ave. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Feb. 29 1924
20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT LOCATION OF DISEASE TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84339 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99 D 84339

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Queen Anne Rd ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Stankloff

(a) RESIDENCE. NO. 8 Queen Anne Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Carl F. Stankloff

6 DATE OF BIRTH (month, day, and year): Oct 22 1843

7 AGE: Years 80 | Months 4 | Days 0 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christian Lorenz Lertz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magadelin Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: C. V. Stankloff (Address) 8 Queen Anne Rd

15

FEB 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18th, 1924, to Feb. 27th, 1924, that I last saw her alive on Feb. 27th, 1924, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary): Ac. Bronchitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. W. Keown, M. D.

(Address) 1938 Linden Ave

2/28/1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Mch / DATE OF BURIAL: 1924

20 UNDERTAKER: Chas. E. Franck ADDRESS: 807 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is necessary TION is very important. See instructions on back of certificates.

FILMED

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84340 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-002 D 84340

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Baacke

(a) Residence No. 2428 Frederick Ave St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. / mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katie McGolrick

6-DATE OF BIRTH (month, day and year) Jan 13 1864

7-AGE. 60 yrs. / mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cooper

(b) General nature of Industry, business, or establishment in which employed (or employer) Std Oil Co

(c) Name of [illegible]

9-BIRTHPLACE (city or town) Ballo (State or Country) Maryland

PARENTS

10-NAME OF FATHER Fabian Baacke

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Ina Kraguer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Wife (Address) 2428 Frederick Ave

15- FEB 29 1924 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 26/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 24 19 24 to Feb 26 19 24

that I last saw h. alive on Feb 26 19 24

and that death occurred, on the date stated above, at 10 48 m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Punctured

(Signed) H. O. Harper M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount DATE OF BURIAL. Feb 29 1924

20-UNDERTAKER. H B Phillips ADDRESS 1236 Fred Ave

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Chief Permit Clerk.

ROBERT R. KRAUTER,

KODAK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84341

100-001

CERTIFICATE OF DEATH.

D 84341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 322 S. Smallwood St. WARD 10)

2-FULL NAME Dorothy May Kemp

(a) RESIDENCE No. 322 S. Smallwood St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 1921

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Walter E. Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Verona M. Post

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Walter E. Kemp
(Address) 322 S. Smallwood

15 FEB 29 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17 I HEREBY CERTIFY, That I attended deceased from February 25, 1924, to February 27 1924, that I last saw h[illegible] alive on February 27, 1924, and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Otitis media, Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert D. Gray M. D.

(Address) 251 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Western Cemetery

DATE OF BURIAL Feb 29 1924

20 UNDERTAKER H. B. Hepfner

ADDRESS 2236 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—1-12-2[illegible]—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84342

CERTIFICATE OF DEATH.

31 D 84342

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 Patterson Place ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Connor

(a) RESIDENCE No 1929 Patterson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): March 9/1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer 40
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. W. Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Amelia Brashears

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Robt. H. Connor
(Address): 1812 N. Duncan St

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Reported treated at Mercy Hospital)
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Culler, M. D.
(Coroner.)

Feb 28/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Feb 29 192 4
20 UNDERTAKER	ADDRESS
Wendell Appel & Son	378 N

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84343

CERTIFICATE OF DEATH.

90 D 84343

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Albert Dix

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maine
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-13, 1924, to 2-27, 1924

that I last saw him alive on 2-26, 1924

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Drane, M. D.

2-28 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	Feb. 29 1924
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

METHOD SHOULD BE CAREFULLY CONSIDERED. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84344

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓34344

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 405 E. 27th St ST., 9 WARD)

2-FULL NAME Mary Ellen Carroll

(a) RESIDENCE NO. 405 E. 27th St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph F. Carroll

6 DATE OF BIRTH (month, day and year): June 16 1878

7 AGE: Years 45; Months 8; Days 12; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William T. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary E. Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City of York, Pa.

14 Informant (Address): Joseph F. Carroll 405 E. 27th St

15 Filed ..... 19 ..... Burial Permit Clerk ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): February 28th 1927

17 I HEREBY CERTIFY, That I attended deceased from Jan 27th, 1923, to Feb 28th, 1927, that I last saw her alive on Feb 28th, 1927, and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. 13 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jos W Montgomery M.D.

(Address) 405 E 27th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 3/3 1927

20 UNDERTAKER: Wm Cook

ADDRESS: 504 W North Ave

BEFORE WRITING BE CAREFUL that this certificate may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See Instructions on back of certificates.

FEB 29 1928

Burial Permit Clerk

Cor.--t-tz-zi--M&T--100 Bks.

Dr Hennessy Wm

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84345

CERTIFICATE OF DEATH.

Inwood 84345

1-PLACE OF DEATH 533 North Stricker St

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Sallie P Conway.

(a) RESIDENCE NO. 533 North Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1943

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer Md

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Minus Conway.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jane Goswell

13 BIRTHPLACE OF MOTHER (city or town) Delaware
(State or country)

14 Informant Edith L Spence
(Address) 533 No Stricker St

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

Feb. 29, 1924 (Address) 2802 Eddendale Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	March 1, 1924

20 UNDERTAKER Wm Tevis & Son ADDRESS

CAUSE OF DEATH: Fill in plain terms, so that any physician can understand it. Do not use abbreviations or technical terms. Do not state mode of dying, such as heart failure, asthenia, etc., but the disease or injury that caused death. Non-contagious diseases of a child should be reported as such, and not as "stillborn" or "premature birth." Deaths from violence must be reported to the Coroner. Deaths from contagious diseases must be reported to the Health Officer. Deaths from tuberculosis must be reported to the Tuberculosis Commission. Deaths from cancer must be reported to the Cancer Commission. Deaths from pellagra must be reported to the Pellagra Commission. Deaths from infantile paralysis must be reported to the Infantile Paralysis Commission. Deaths from typhoid fever must be reported to the Typhoid Commission. Deaths from diphtheria must be reported to the Diphtheria Commission. Deaths from scarlet fever must be reported to the Scarlet Fever Commission. Deaths from measles must be reported to the Measles Commission. Deaths from whooping cough must be reported to the Whooping Cough Commission. Deaths from mumps must be reported to the Mumps Commission. Deaths from chickenpox must be reported to the Chickenpox Commission. Deaths from smallpox must be reported to the Smallpox Commission. Deaths from rabies must be reported to the Rabies Commission. Deaths from anthrax must be reported to the Anthrax Commission. Deaths from glanders must be reported to the Glanders Commission. Deaths from hydrophobia must be reported to the Hydrophobia Commission. Deaths from tetanus must be reported to the Tetanus Commission. Deaths from botulism must be reported to the Botulism Commission. Deaths from trichinosis must be reported to the Trichinosis Commission. Deaths from tularemia must be reported to the Tularemia Commission. Deaths from undulant fever must be reported to the Undulant Fever Commission. Deaths from Weil's disease must be reported to the Weil's Disease Commission. Deaths from yellow fever must be reported to the Yellow Fever Commission. Deaths from dengue must be reported to the Dengue Commission. Deaths from sandfly fever must be reported to the Sandfly Fever Commission. Deaths from Rocky Mountain spotted fever must be reported to the Rocky Mountain Spotted Fever Commission. Deaths from typhus fever must be reported to the Typhus Commission. Deaths from relapsing fever must be reported to the Relapsing Fever Commission. Deaths from leprosy must be reported to the Leprosy Commission. Deaths from syphilis must be reported to the Syphilis Commission. Deaths from gonorrhea must be reported to the Gonorrhea Commission. Deaths from chancroid must be reported to the Chancroid Commission. Deaths from granuloma inguinale must be reported to the Granuloma Inguinale Commission. Deaths from lymphogranuloma venereum must be reported to the Lymphogranuloma Venereum Commission. Deaths from trachoma must be reported to the Trachoma Commission. Deaths from inclusion conjunctivitis must be reported to the Inclusion Conjunctivitis Commission. Deaths from ophthalmia neonatorum must be reported to the Ophthalmia Neonatorum Commission. Deaths from blennorrhea must be reported to the Blennorrhea Commission. Deaths from conjunctivitis must be reported to the Conjunctivitis Commission. Deaths from keratitis must be reported to the Keratitis Commission. Deaths from iritis must be reported to the Iritis Commission. Deaths from cyclitis must be reported to the Cyclitis Commission. Deaths from choroiditis must be reported to the Choroiditis Commission. Deaths from retinitis must be reported to the Retinitis Commission. Deaths from optic neuritis must be reported to the Optic Neuritis Commission. Deaths from papilledema must be reported to the Papilledema Commission. Deaths from glaucoma must be reported to the Glaucoma Commission. Deaths from cataract must be reported to the Cataract Commission. Deaths from amaurosis must be reported to the Amaurosis Commission. Deaths from blindness must be reported to the Blindness Commission. Deaths from deafness must be reported to the Deafness Commission. Deaths from otitis must be reported to the Otitis Commission. Deaths from mastoiditis must be reported to the Mastoiditis Commission. Deaths from labyrinthitis must be reported to the Labyrinthitis Commission. Deaths from meningitis must be reported to the Meningitis Commission. Deaths from encephalitis must be reported to the Encephalitis Commission. Deaths from myelitis must be reported to the Myelitis Commission. Deaths from neuritis must be reported to the Neuritis Commission. Deaths from neuralgia must be reported to the Neuralgia Commission. Deaths from sciatica must be reported to the Sciatica Commission. Deaths from lumbago must be reported to the Lumbago Commission. Deaths from rheumatism must be reported to the Rheumatism Commission. Deaths from arthritis must be reported to the Arthritis Commission. Deaths from osteomyelitis must be reported to the Osteomyelitis Commission. Deaths from periostitis must be reported to the Periostitis Commission. Deaths from synovitis must be reported to the Synovitis Commission. Deaths from bursitis must be reported to the Bursitis Commission. Deaths from tenosynovitis must be reported to the Tenosynovitis Commission. Deaths from myositis must be reported to the Myositis Commission. Deaths from fibrositis must be reported to the Fibrositis Commission. Deaths from panniculitis must be reported to the Panniculitis Commission. Deaths from adenitis must be reported to the Adenitis Commission. Deaths from lymphangitis must be reported to the Lymphangitis Commission. Deaths from phlebitis must be reported to the Phlebitis Commission. Deaths from thrombosis must be reported to the Thrombosis Commission. Deaths from embolism must be reported to the Embolism Commission. Deaths from aneurysm must be reported to the Aneurysm Commission. Deaths from arteriosclerosis must be reported to the Arteriosclerosis Commission. Deaths from cerebral hemorrhage must be reported to the Cerebral Hemorrhage Commission.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84346

D 84346

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ludwig ave & Derby La ST., 15 WARD)

2-FULL NAME Frank. J. Imbach

(a) RESIDENCE NO. Ludwig Ave & Derby La. ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura C. Imbach

6 DATE OF BIRTH (month, day, and year) April 15 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supervisor 086

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Yard.

(c) Name of employer Balto Dry Docks.

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Frank Imbach.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Shidell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura C. Imbach
(Address) Ludwig ave & Derby La.

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1924, to February 28, 1924, that I last saw him alive on February 27, 1924, and that death occurred, on the date stated above, at 12.00 N m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) yrs. 4 mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 2, 1924

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Fu Stevens, M. D.

3/28, 1924 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 3 1924
20 UNDERTAKER	ADDRESS
Wm Levick for E. Hanley	

mation should be given. Exact statement of occupation is necessary. If birth in hospital, institution or tenement house, the NUMBER should be given. Causes of death must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Kolb 1202 Eutaw St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84347

CERTIFICATE OF DEATH.

1749 D 84347

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 267 W. 31 st St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Crawford

(a) Residence No. 267 W. 31 St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Crawford

6-DATE OF BIRTH (month, day and year) Dec 25 1847

7-AGE. 66 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fire Patrol

(b) General nature of Industry, business, or establishment in which employed (or employer) 06

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elijah Crawford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Emma E Stutchins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Maud L Lynch

(Address) 267 W. 31 St

15-

FEB 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 28 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 2 23 19.. to Feb 28 24 19..

that I last saw him alive on Feb 27 24 19..

and that death occurred, on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia Influenza

Acute Lobar Pneumonia (Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis Liver

Acute Lobar Pneumonia (Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Hr

Did an operation precede death? Hr Date of —

Was there an autopsy? Hr

What test confirmed diagnosis?

(Signed) Thos P Kolb M. D

Feb 29 24 (Address) 1202 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Plum Point Md	Mar 1 1924
20-UNDERTAKER.	**ADDRESS**
W. Cook	502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 84348 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84348

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Brown

(a) RESIDENCE NO. 1816 Woodyear St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5. 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Gertrude Flushman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rochester N.Y.

14 Informant Mrs Eva Brown (Address) 1816 Woodyear St

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from January 21, 1924, to Feb. 27, 1924, that I last saw her alive on Feb. 27, 1924, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Idiopathic peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of Feb. 25-24

Was there an autopsy? No Observed & Diagnosed - post mortem.

What test confirmed diagnosis? P. S. & Operation

(Signed) J. Pozzelichi, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar 3 1924
20 UNDERTAKER Wm Cook	ADDRESS 532 E Fayette Ave

MATTER SHOULD BE PRINTED, Supplied. Exact statement of occupation CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84349

CERTIFICATE OF DEATH.

+ 118-002

D 84349

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., W WARD)

2-FULL NAME Miss Bertha Harrison

(a) RESIDENCE NO. Bridgeville Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bridgeville Va
(State or country)

PARENTS

10 NAME OF FATHER George Harrison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mammie Tize

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant George Harrison
(Address) Fairport, Va.

15 FILED FEB 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-24. 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924, to Feb. 28, 1924,
that I last saw h[illegible] alive on Feb. 28, 1924,
and that death occurred, on the date stated above, at 4.30 P.m.
The CAUSE OF DEATH* was as follows:
Peritonitis; Intestinal Obstruction

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Ruptured appendix.

(duration) ..... yrs. ..... mos. 2 1 ds.

18 Where was disease contracted if not at place of death? Bridgeville Va.

Did an operation precede death? No Date of Feb. 9, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible] M. D.

, 19 (Address) Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairport, Va — DATE OF BURIAL: Mar 2 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette Ave.

INFORMATION SHOULD BE GIVEN BY PERSON BEST QUALIFIED. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12323-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 84350

D 84350

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Cummings

(a) Residence No. Bay View asylum St. ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 11 1844

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) OP
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Ireland

PARENTS.

10-NAME OF FATHER, John Cummings

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Mary Cummings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Municipal Hospital Records

(Address)

15- Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-28-24

17- I HEREBY CERTIFY, That I attended deceased from 2-25, 1924 to 2-28 1924 that I last saw h. alive on 2-28 1924 and that death occurred, on the date stated above, at 1 10 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude S. Druce, M. D

2-28. 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine Park Cem

DATE OF BURIAL, March 1, 1924

20-UNDERTAKER, George J Smith

ADDRESS 1532 Hollins st

in plain terms, so that it may be properly classified. Exact statement of cause of death required. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84351

CERTIFICATE OF DEATH.

3/ D 84351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Watson ST., 3 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Jones 909 Watson

(a) RESIDENCE No ..... ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35 1			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14
Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar
1185 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 B- Pulmon

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) G. C. Yates, M. D.
(Coroner.)

Feb 28 1924 (Address) 1123 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
HOPKINS HOSPITAL	FEB 28 1924
20 UNDERTAKER Commissioner Health, Per. Wm. F. WOODALL	ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rls.

D 84352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84352

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Warden ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Salomone

(a) RESIDENCE NO. 1004 Warden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1 - 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City Md.
(State or country)

PARENTS

10 NAME OF FATHER Paolo Salomone

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Giuseppa Tesoro

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Paolo Salomone
(Address) 1004 Warden St

15

FEB 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 26, 1924, to Feb 28, 1924.

that I last saw her alive on Feb 27, 1924

and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. Di Stefano M. D.

Feb 28, 1924 (Address) 407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	3/1/24

20 UNDERTAKER	ADDRESS
Geo J. Kelly	1733 Hanford Ave.

IMPORTANT STATEMENTS WITH REGARD TO CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84353

D 84353

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 W 36th St. No WARD)

2-FULL NAME Samuel J Keeler

(a) RESIDENCE NO. 5 N Clinton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ ✓

6 DATE OF BIRTH (month, day, and year) Oct 31 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER James H Keeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Nellie Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Ruth Ebert

(Address) 5 N Clinton St

15 Filed FEB 29 1924 19 Registrar ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1923 to Feb 29 1924.

that I last saw him alive on Feb 29 1924,

and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pharynx

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J W Worthington M. D.

2/29 1924 (Address) 2020 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Carmel Cem	March 3 1924

20 UNDERTAKER CRENOWETH & SON ADDRESS 317 CHESTNUT AVE.

Please state clearly that it may be properly classified. Exact statement of decedent's OCCUPATION and CAUSE OF DEATH in plain terms, so

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84354

CERTIFICATE OF DEATH.

X 12 ✓

D 84354

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 1 W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr Albert Ponsford

(a) RESIDENCE NO. 106 Elgin Street Ontario Canada WARD Ontario Canada
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Albert Ponsford,

6 DATE OF BIRTH (month, day, and year) Sept 16 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor 016

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ontario Canada.

PARENTS

10 NAME OF FATHER George Ponsford

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Union Memorial Hospital Records (Address)

FEB 29 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to Feb 28, 1924, that I last saw him alive on Feb 28, 1924, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Fibroma of the Pancreas, Operated on & died of surgical shock

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Ontario Canada.

Did an operation precede death? Yes Date of Feb 28, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Raymond F. Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas - Ontario Can	2-29 1924
20 UNDERTAKER	ADDRESS
Percy W Jenkins Undertaking Co	Mitchell Orchard

information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1-24—M&T—1500 Bks.

D 84355 D 84355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH John Hopkins Hosp. 14

CITY OF BALTIMORE: (No. ..... St. ..... Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Brown

(a) RESIDENCE No. St. Vincent Inf Asylum WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown. ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown. ?

14 Informant Records
(Address) John Hopkins Hosp

15 Filed FEB 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924, to Feb 26, 1924.

that I last saw him alive on Feb 26, 1924.

and that death occurred, on the date stated above, at 12-10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Rhacic Ricketts ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At St. Vincents Asylum

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Carter Falkner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cemetery	Feb 29 1924
20 UNDERTAKER Martin Tuskes & Sons	ADDRESS 1827 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given. Do not use abbreviations. Write plainly with pen and ink. Information should be carefully supplied, so that it may be properly classified. Exact statement of occupation should be given. Do not use abbreviations. Write plainly with pen and ink. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given. Do not use abbreviations. Write plainly with pen and ink. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D 84356 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 90

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lonny Ward

(a) RESIDENCE NO. 2137 Druid Hill Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) .....

7 AGE: Years 32. | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mother (Address) 2137 Druid Hill Ave

15 Filed ..... 19 ..... Robert P. Harris, Registrar

EB 29 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/18/24, 19..... to 2/26/24, 19.....

that I last saw h[illegible] alive on 2/26/24, 19.....

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio vascular Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus Viridans Subacute Endo[illegible]

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL March 1924

20 UNDERTAKER Jas. C. Ford | ADDRESS 2319 Pennsylvania

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84357

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Division ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Nelson

(a) RESIDENCE NO. 2225 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Eliza Nelson

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	50	Don't know		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Reide

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Lloyd Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Mrs John A Nelson

(Address) 2225 Division

B 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 27 . 1924 . to Feb 27 . 1924 .

that I last saw h.. alive on Feb 27 . 1924 ,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 10 hours yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Fred C Jewett, M. D.

Feb 28 1924 (Address) 2516 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: Mar 2 1924

20 UNDERTAKER: Mrs James H. Dennis

ADDRESS: 1303 Pressman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84358

CERTIFICATE OF DEATH.

D 84358

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Kriss

(a) RESIDENCE No. 920 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Andrew Kriss

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Anna Bergie

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant ..... JOHNS HOPKINS HOSPITAL.
(Address)

15 Robert F. Harrison, .19.....
Registrar

B 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 -, 1924, to Feb 28, 1924, that I last saw him alive on Feb 28, 1924, and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Primary

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) A. A. Weech, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Mch 3, 1924
20 UNDERTAKER Burkhart & Burkhart	ADDRESS 1739 Eager

MAKE ENTRIES in ink or typewriting, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84359

CERTIFICATE OF DEATH.

14 100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Mateu

(a) Residence No. 2122 Etting St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE.	If LESS than 1 day.
65 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, Business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) St. Marys Co. (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Peter Biscoe

11-BIRTHPLACE OF FATHER (city or town) St. Marys Co. (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Jenney Biscoe

13-BIRTHPLACE OF MOTHER (city or town) St. Marys Co. (State or Country) Maryland

11- (Informant) Dave Carton

(Address) 916 6th

15- Filed 2-29 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-27-24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 16 1924 to Feb. 27 1924, that I last saw her alive on Feb. 27, 1924, and that death occurred, on the date stated above, at 1-45 P. m.

The CAUSE OF DEATH* was as follows:

Bronko pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Sutton M. D

19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn	1-3 19 24
20-UNDERTAKER. David Carton	ADDRESS 916 6th

in plain terms, so that it may be properly classified. Read instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84360

CERTIFICATE OF DEATH.

REGISTERED NO. 101-201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Bruce ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Green

(a) RESIDENCE NO. 716 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General house work

(c) Name of employer Mrs. Kaufg. Herbert 1920

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Chas. Co. Md.

12 MAIDEN NAME OF MOTHER Lucinda Jenkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Essex Co. Va.

14 Informant Lucinda Green

(Address) 716 N. Bruce St.

3 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-28- 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27- 1924, to Feb-28- 1924.

that I last saw h-e alive on Feb. 28- 1924,

and that death occurred, on the date stated above, at 6-50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carlen Cem

DATE OF BURIAL 1-3 1924

ADDRESS 916

20 UNDERTAKER Dan'l Taylor's

Ca as

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84361

CERTIFICATE OF DEATH.

123 D 84361

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 222 Oakley ave ST., 7 WARD)

2-FULL NAME Margarette Amelia Brooks

(a) RESIDENCE NO. 222 Oakley ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Brooks Jr.

6 DATE OF BIRTH (month, day, and year) July 23-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Bautz

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Hannah Torpey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hannah Bautz (Address) 2828 Clifton ave

15 Robert P. Harrison, Registrar

3 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27" 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/20 1924, to 2/27 1924, that I last saw h-e alive on 2/27 1924 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Heart Collapse

(duration) yrs. 1 mos. Dys.

CONTRIBUTORY (Secondary) Influenza Pneumonia attack

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H K Hurley, M. D.

, 19 (Address) 1340 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/1 1924

20 UNDERTAKER Chas. P. Ware & Son

ADDRESS 1180 West Royalton.

mation should be carefully supplied. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84362

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1226 Washington Boulevard 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elijah W. Lee

(a) Residence No. 1226 Washington Boulevard, Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara E. Lee

6-DATE OF BIRTH (month, day and year) April 25 1844

7-AGE. 79 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None-Retired Foreman

(b) General nature of industry, business, or establishment in which employed (or employer). Balto. Brick Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Mr. Lee

11-BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)

12-MAIDEN NAME OF MOTHER, Mr. Brown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14-(Informant) Elijah O. Lee

(Address) 1226 Washington Blvd.

15-Filed..... Robert P. Harrison
Registrar.

B 2 9 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1923 to Feb 27, 1924 that I last saw h[illegible] alive on Feb 27 1924 and that death occurred, on the date stated above, at 8.15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Nephritis

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Richard Brain, M. D.

2-28, 1924 (Address) 1227 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL, Mar. 1st, 1924

20-UNDERTAKER: Edw. L. Cook ADDRESS 1003 N. Bethel St.

Instructions: Physicians are requested to fill out all items in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84363

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Eutaw Pl. ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss. Zenobia Hickman

(a) RESIDENCE NO. 2405 Eutaw Pl. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress for 4 yrs

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Hickman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Margaret S. Floyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant James E. Godwin
(Address) Old Orchard Rd. Ten Hills

FEB 29 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20 - 1924 to Feb. 27 1924, that I last saw her alive on Feb. 27 1924, and that death occurred, on the date stated above, at 8-40 P. m.

The CAUSE OF DEATH* was as follows

Cerebral hemorrhage

(duration) - yrs. - mos. 8 ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCarthy, M. D.

2/27, 1924 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glen Mount Cem	Mar 1st 1924
20 UNDERTAKER	ADDRESS
Geo. L. Cook	1603 W. Balto St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—3-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84364

CERTIFICATE OF DEATH.

66 D 84364

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 N. Brice St ST. 16 WARD)

2-FULL NAME Jeremiah A. Dee

(a) RESIDENCE NO. 628 N. Brice St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John J. Dee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Enright

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Ellen Dee
(Address) 628 N. Brice St.

15 Filed ....., 19.....

B 29 1924 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1924 to Feb. 27, 1924.

that I last saw him alive on " " 1924.

and that death occurred, on the date stated above, at 5. A. m.

The CAUSE OF DEATH* was as follows

Acute Alcoholism

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Delirium Tremens 5 das.

Oedema Of brain (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. M. Costelloe M. D.

2/29 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	3/1 1924

20 UNDERTAKER Chas. J. Cowan & Son. ADDRESS 901 Hollins

Chas. J. Cowan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of each of certificates. See instructions on back of certificate. TION is very important.

Spec--12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84365

D 84365

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.) 3562 Poole St. St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank M. Rogers

(a) Residence No. 3562 Poole St. St., 13 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie M. Rogers

6-DATE OF BIRTH (month, day and year) May 19-1866

7-AGE, 57 yrs. 9 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Wm. E. Hooper & Sons Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Co. Maryland

PARENTS.

10-NAME OF FATHER. James Rogers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary L. Shanck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-

(Informant) Mrs. Maggie M. Rogers

(Address) 3562 Poole St.

15-

Filed ..... 192.. Robert F. Carrick, Registrar.

FEB 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 28-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 14 1924 to Feb 28 1924

that I last saw h— alive on Feb. 28 1924

and that death occurred, on the date stated above, at 11.55 A. m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Woodward M. D.

2/29, 1924 (Address) 846 W 36 & N. Both

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Vernon Hampden — DATE OF BURIAL, March 1, 1924

20-UNDERTAKER, Horace H. Burgee — ADDRESS 363 Falls Road

in plain terms, so that it may be properly classified. instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Shirley S. Kershaw)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84366

CERTIFICATE OF DEATH.

11 N

D 84366

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley S. Kershaw.

(a) RESIDENCE NO. 1009 Bolton Lane ST. 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Kershaw.

6 DATE OF BIRTH (month, day, and year): July 22 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Wrecking Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Edwin Kershaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Martha McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records

(Address)

15 Filed ....., 19.....

Robert F. Harrison, Registrar

Burial Permit Clerk.

FEB 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/29/24

17 I HEREBY CERTIFY, That I attended deceased from 2/17/24, 19..., to 2/29/24, 19...

that I last saw h... alive on 2/29/24, 19...

and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 2/22/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden

DATE OF BURIAL: March 3 1924

20 UNDERTAKER: Horace F. Burgee

ADDRESS: 3631 Falls Rd

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84367

CERTIFICATE OF DEATH.

100-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S. Spring ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jake Lowndes

(a) RESIDENCE No. 232 S. Spring ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) sept 6. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto city sub
(State or country)

PARENTS

10 NAME OF FATHER Jake, conner

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) station georgia

12 MAIDEN NAME OF MOTHER annie morgan

13 BIRTHPLACE OF MOTHER (city or town) Balto md
(State or country)

14 Informant annie morgan
(Address) 232 S. Spring St

15 Filed 1-1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lob. Bronchitis

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Edocarditis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Jas Clinton Blades, M. D.
(Coroner)

Jan 29 1924 (Address) 143 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Mar 1-24

20 UNDERTAKER Edward Bryan — ADDRESS 1031 Orleans St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84368

CERTIFICATE OF DEATH.

129 D 84368

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 E Monument ST., 10 WARD)

2-FULL NAME John. M. Baublitz

(a) RESIDENCE No. 1108 E Monument - ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 52 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma. F. Baublitz

6 DATE OF BIRTH (month, day, and year) Nov. 7 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER John. H. Baublitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Emma. F. Baublitz

(Address) 1108 E. Monument St

15 Filed ..... 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1923 to Feb. 29, 1924, that I last saw ~~him~~ alive on Feb 29 1924, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John D Fisch M. D.

3/29 1924 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem. Md.	March 3 1924
20 UNDERTAKER	ADDRESS
Henry Hook Son	1809 E Eagle

MAR 1 - 1924

Burial Permit Clerk.

IMPORTANT—Before filling out this certificate, read carefully the instructions on back of certificates. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84369

CERTIFICATE OF DEATH.

100-00

D 84369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 67 Raspe Ave ST., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Stubbel

(a) RESIDENCE No. 67 Raspe Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 7 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	4	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Augustine Stubbel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary A. Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Wm. Augustine Stubbel
(Address) 67 Raspe Ave

15 Filed MAR 1 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1924, to Feb 29th, 1924, that I last saw him alive on Feb 29th, 1924, and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Acute Fulminating Type)
(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Heart Failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Suspected sputa

(Signed) L. M. C. Barker, M. D.

(Address) 1114 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL: March 1924

20 UNDERTAKER: Henry Hoeck Son ADDRESS: 1201 E Eager St

MARK SHOWING DEATH CERTIFICATE SHOULD BE FILED. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1000 Bks.

16 D 84370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 D 84370

1 PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME Virginia Coleman

(a) RESIDENCE NO. 2803 Huntington Av WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 4, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Pete Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Bernice Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... Registrar

Burial Permit Issued

R 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Feb 29, 1924.

that I last saw h[illegible] alive on Feb 29, 1924.

and that death occurred, on the date stated above, at 5-45 A. m.

The CAUSE OF DEATH* was as follows:

Vomiting and diarrhoea (most dysentery)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Weech, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Freedom Pa

DATE OF BURIAL March 1 1924

20 UNDERTAKER CHENOWETH & SON, 3617 CHESTNUT AVE.

ADDRESS

IMPORTANT—Before signing, read carefully, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 84371

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 603 Richmond Ave ..... Ward) 21

2-FULL NAME Chas Frederick Ritter

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 603 Richmond Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) August 15 1851

7-AGE, 72 yrs. 6 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Chair

(b) General nature of industry, business, or establishment in which employed (or employer): Maker. 014

(c) Name of employer: .....

9-BIRTHPLACE (city or town), (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frederick W. Ritter

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Melle Hanover - Germany

12-MAIDEN NAME OF MOTHER, Sophia N.

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Pyrmont Waldeck Germany

14- (Informant) 603 Richmond Ave

(Address) William J. Ritter

15- Filed ..... 192.....
Actg. R. Marriott,
Registrar.

MAR 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1924 to Feb 28 1924, that I last saw h. alive on Feb 25 1924, and that death occurred, on the date stated above, at 10 20 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Bronchio Pneumonia

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas Simmons, M. D

2/29/1924 (Address) 4 Rock Hall

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery Co	March 1, 1924
20-UNDERTAKER.	**ADDRESS**
Geo. J. Routh	1735 Harford Ave.

in plain terms, so that it may be properly classified. Exact treatment of [illegible] instructions on back of certificates.

Spec.- 1-10-21- M&T- 1500 Bks.

D 84372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84372

CERTIFICATE OF DEATH.

REGISTERED NO. 10

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 347 S. Luzon ST., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin K. Schuhmacher

(a) RESIDENCE NO. 347 S. Luzon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Feb yrs. 29 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Phillip G. Schuhmacher

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Dora M. Keifer

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Phillip G. Schuhmacher

(Address) 347 S. Luzon St

15 Filed AR 1 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924 to Feb 29, 1924.

that I last saw him alive on Feb 29, 1924.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: (a) Bronchopneumonia

(duration) no yrs. 0 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Raymond W. Glenn M. D.

19 (Address) 1111 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Mar 1, 1924

21 UNDERTAKER George L. Schwadt — ADDRESS 210 Biddle St

FORM should be CAREFULLY answered. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84373

CERTIFICATE OF DEATH.

D 84373

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Hanover Street. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Jackson. (C).

(a) RESIDENCE No 712 Hanover Street ST., WARD Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 8 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of ~~(or) WIFE of~~ Etta Jackson. (C)

6 DATE OF BIRTH (month, day, and year) March 30, 1901.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	10	29.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina.

PARENTS

10 NAME OF FATHER James Jackson. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nellie Brown. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina.

14 Informant Etta Jackson. (C). (wife)
(Address) 712 Hanover Street

15 Filed MAR 1-1924 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Bernhardt M. D. (Coroner.)

March 1, 1924 (Address) 1514 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL Mch 1 1924

20 UNDERTAKER S. P. Brown & Son — ADDRESS 108 N. Monroe

Burial Permit Chesapeake Line to Norfolk Va

Spec.—1-10-21—M&T—1500 Blks.

D 84374 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84374

CERTIFICATE OF DEATH. X 131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 N Mount ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Hawkins

(a) RESIDENCE NO. 1512 N Mount ST., WARD Wash. Co.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of [redacted] Francis Hawkins

6 DATE OF BIRTH (month, day, and year) Not Known 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cecelia Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) Mrs Robert A Elliott

15 Robert F. Matthews Registrar

MAR 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924, to Feb 29, 1924.

that I last saw him alive on Feb 29, 1924,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pyo-nephrosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute Catharral Jaundice (duration) yrs. mos. 3

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab.

(Signed) R J Young, M. D.

2/27/1924 (Address) 1424 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington, D C — DATE OF BURIAL March 4, 1924

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland

METHOD should be carefully observed. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important

Spec.—1-10-21—M&T—1500 Blks.

D 84375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84375

CERTIFICATE OF DEATH.

100-001

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1051 N Durham ST., 7th WARD)

2-FULL NAME Beatrice McClaren

(a) RESIDENCE No. 1051 N Durham ST., WARD 7th

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23/23

7 AGE — Years: — Months: 3 Days: 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Mc Claren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bal N Carolina

12 MAIDEN NAME OF MOTHER Bertha McClaren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Carolina

14 Informant My Farther James Claren

(Address) 1103-1 N Durham St

15 Robert F. Mattson, 19 Registrar

Burial Permit clerk.

R 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1924

17

I HEREBY CERTIFY, That I attended deceased from February 1, 1924, to Feb 28, 1924, that I last saw h[illegible] alive on Feb 27th, 1924, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Bronchitis

which Developed in

Bronchial Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas J Emmus, M. D.

19 (Address) 102 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL March 1 1924

20 UNDERTAKER Mrs R A Elliott — ADDRESS 1725 Ashland Ave

IMPORTANT—Physician should be careful in filling supplies. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84376 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84376

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 414 S. 12th St. St., 26 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Haroldsen

(a) Residence No. 414 S. 12th Sts. St., ... Ward West Hoboken N.J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Haroldsen

6-DATE OF BIRTH (month, day and year) Dec 11-1861

7-AGE. 62
62 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Sweden

PARENTS.

10-NAME OF FATHER, Herman Hermansen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Sweden

12-MAIDEN NAME OF MOTHER Johanna Andersen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Sweden

14- (Informant) Sally T. Braff
(Address) 3982 Hudson Blvd. ~~West Hoboken N.J.~~

15- Filed ..... 192 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb- 29 - 1924, to March 1, 1924 that I last saw her alive on Feb-29, 1924, and that death occurred, on the date stated above, at 2.50 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. Gill Hall, M. D

March 1. 1924 (Address) 1631 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
West Hoboken N. J.	March 1. 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Pleasant St

MART - 1924

in plain terms, so that it may be properly classified. Exact statement of cause of death required. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84377

CERTIFICATE OF DEATH.

90 D 84377

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1734 Bank St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob H. Miller

(a) Residence No. 1734 Bank St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 1, 1841

7-AGE. 82 yrs. 2 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gracer 034

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1 year

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Eva A. Eggers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Eva E. Matthai

(Address) 1734 Bank St

15-

Filed ... 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 27, 24

17- I HEREBY CERTIFY, That I attended deceased from July — 1923 to Feb. 27 1924

that I last saw h— alive on Feb 27 1924

and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Senility — Arg. Vascular Syphilis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sub acute Bronchitis

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) John C Brown M. D

(Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 3, 1924
20-UNDERTAKER,	ADDRESS
H. Sander Sons	1710 East

In plain terms, so that it may be properly classified. Exact statement of occupation required. Indefinite terms, such as laborer, housekeeper, etc., will not be accepted. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Time of burial extended to monday 10 A.M. March 3/24
J. Edward C. Hempel asst Coroner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84378

CERTIFICATE OF DEATH.

REGISTERED NO. 25 84378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Poca St Mt Winans ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw J. Miller

(a) RESIDENCE NO. 21 Poca St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Cald

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 16-1923

7 AGE: 1 Years 1 Months Days | If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mt Winans Md
(State or country)

PARENTS

10 NAME OF FATHER Wm J. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary Miller
(Address) 21 Poca St

15 Filed . 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MAR 1 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-29-1924

17

I HEREBY CERTIFY, That I attended deceased from 2-26, 1924, to 2-29, 1924,

that I last saw h alive on 2-29-, 1924,

and that death occurred, on the date stated above, at 3 8. m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Hall, M. D.

, 19 (Address) Holliday St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL March 1924

20 UNDERTAKER A. Jones — ADDRESS 111 S Gilmor

21

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Turner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84379

CERTIFICATE OF DEATH.

X 88

D 84379

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Joanna Turner

(a) RESIDENCE NO. Mount Hope Retreat ST. 28th WARD Grafton W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 21 ds. How long in U. S., if of foreign birth? was born mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Turner

6 DATE OF BIRTH (month, day, and year) (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	73	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (?)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland -

PARENTS

10 NAME OF FATHER James Russell

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md -

15 Filed ....., 19.... [illegible] Registrar

R 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8th 1924 to Feb 29th 1924 that I last saw her alive on Feb 29 1924 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis - Suddenly -

abt (duration) 0 yrs. 0 mos. 1/2 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

abt (duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Grafton W. Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Feb 29th 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grafton W. Va. DATE OF BURIAL March 1 1924

20 UNDERTAKER MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 59 (Peter Dennen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84380 D 84380

CERTIFICATE OF DEATH. 1 179

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Maryland General Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Dennen

(a) RESIDENCE No. Reedville Virginia ST., WARD Reedville Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) about 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Hospital Records (Address)

15 Robert F. Harrison, Filed ....., 19..... [illegible] Clerk. Registrar

21 -1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 24

17 I HEREBY CERTIFY, That I attended deceased from February 21, 1924, to February 28, 1924, that I last saw him alive on February 28, 1924 and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

Chronic Nephritis

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Feb 23.

Was there an autopsy? no

What test confirmed diagnosis? Operation Clinical

(Signed) James Hubert Patterson, M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reedville Va	Mar 2 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard St

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84381

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84381

CERTIFICATE OF DEATH. 13

1-PLACE OF DEATH

City of BALTIMORE: (No. 1220 Union Ave St., Ward)

2-FULL NAME William J. Crowe

(Residence in Baltimore: No. 1220 Union Ave St.; yrs., mos., ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1852 (Year)

7-AGE.	If LESS than 1 day,
72 yrs. mos. ds.	hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Police
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) On board a ship bound from Ireland to the United States

PARENTS.

10-NAME OF FATHER. Miles Crowe

11-BIRTHPLACE OF FATHER, (State or Country) Ireland

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER, (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miles Crowe

(Address) 1220 Union Ave

15- MAR 1 - 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 28 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Pleurisy
Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. A. Corner M. D. (Coroner.)

Feb 29 1924 (Address) 3692 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	March 3 1924
20-UNDERTAKER,	ADDRESS
Martin Turkey Lay	512 N Paca

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84382

CERTIFICATE OF DEATH.

D 84382

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1519 Hanover St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Burke

(a) Residence No. 1519 Hanover St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Burke

6-DATE OF BIRTH (month, day and year) July 20 1860

7-AGE.	If LESS than 1 day,
63 yrs. 7 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer). P. & R. R. R.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Howard Co. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Burke

11-BIRTHPLACE OF FATHER (city or town) Scotland (State or Country).

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country).

14-

(Informant) Elizabeth Burke

(Address) 1519 Hanover St.

15-

Filed 1924 Robert F. Barnes Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1924 to Feb 29 1924

that I last saw h. in alive on Feb 29 1924

and that death occurred, on the date stated above, at 11 H m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Sidney H. Strutt M. D

3/1 1924 (Address) 448 E Fort ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mt. Carmel.	3/3 1924
20-UNDERTAKER.	**ADDRESS**
D. Few McCully	130 E. Fort

Burial Permit Clerk.

R 1

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION to be given. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip E. Loth

(a) RESIDENCE NO. Fullerton, Md. ST., ... WARD Coun.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Ella

6 DATE OF BIRTH (month, day, and year) May 3, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fullerton Md.

PARENTS

10 NAME OF FATHER George Loth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Weissner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fullerton, Md.

14 Informant (Son) George E. Loth
(Address) 217 Baltimore Road

15 Filed 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-20-, 1924, to 2-27-, 1924,

that I last saw him alive on 2-27-, 1924

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,

..... (duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) H. D. Parr, M. D.

3/1, 1924 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 3/3 1924

20 UNDERTAKER J. F. McCully

ADDRESS 130 C. Fort

mation should be carefully supplied. Exact statement of OCCUPA-
may be properly classified.
back of certificates.
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D 84384

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 84384

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3214 Elgin Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie D Dougherty

(a) RESIDENCE NO. 3214 Elgin ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael F. Dougherty deceased

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 72 Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Laurence Grogan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Thos Grogan (Address) 220 Edmondson Ave.

15 Filed MAR 1 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 25 1924, to Feby 28 1924.

that I last saw her alive on Feby 28 1924,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Powers M. D.

, 19 (Address) 921 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents Cemetery

DATE OF BURIAL: 3/3 1924

20 UNDERTAKER: Chas P. Ware & Son ADDRESS 118 W. Royal ave

CAUSE OF DEATH should be certified to by physician, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1B 9857 84385

HEALTH DEPARTMENT—CITY OF BALTIMORE

+ 48 D 84385

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Lee Miller

(a) RESIDENCE NO. 21 N. Calhoun St. WARD Richmond Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Herbert Miller

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Eliza Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 2-1-1924 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924, to Feb 29, 1924.

that I last saw her alive on Feb 29, 1924

and that death occurred, on the date stated above, at 3 50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus Coma

Acid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Furunculosis Staph. aureus

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 3/4 1924

20 UNDERTAKER Robert Burns & Son

ADDRESS Cathedral Hollins

mation should be entirely supplied. Exact statement of Occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupa-
TION is very important. See instructions on back of certificates.

D 84386 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001 D 84386

1-PLACE OF DEATH

City of BALTIMORE: (No. 1024 Hollins St. 18 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Timothy Cohan

(Residence in Baltimore: No. 1024 Hollins St.; 44 yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word)
Male	white	Married

6-DATE OF BIRTH. March Nov 25 1867
(Month) (Day) (Year)

7-AGE. About 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Helper
(b) General nature of industry, business, or establishment in which employed (or employer): Marble yard

9-BIRTHPLACE. (State or Country). Washington D C

PARENTS.

10-NAME OF FATHER. Cohan

11-BIRTHPLACE OF FATHER. (State or Country). Washington D C

12-MAIDEN NAME OF MOTHER. Mary Quigley

13-BIRTHPLACE OF MOTHER. (State or Country). Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin E Mattingly

(Address) 214 Indiana Ave Washington

15- Robert P. Harrison, Burial Permit Clerk.

Filed MAR 1 1924 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 29 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Exhaustion by
Accidental Gas
Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Kerlon M. D. (Coroner.)

3/1 1924 (Address) 708 Calhoun

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
CONGRESINAL CEM WASHINGTON DC	MAR 4TH 1924

20-UNDERTAKER. ROBERT BROOKS & SON

ADDRESS 708 CALHOUN HOLLINS ST

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 84387

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84387

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1026 Hollins St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Cohan

(Residence in Baltimore: No. 1026 Hollins St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: July (Month) 1 (Day) 1861 (Year)

7-AGE: 57 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: Of
(a) Trade, profession, or particular kind of work: Helper 03
(b) General nature of industry, business, or establishment in which employed (or employer): marble yard

9-BIRTHPLACE, (State or Country): Washington D C

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Washington DC

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country): DC

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Mattingly

(Address) 214 Indiana ave Washington DC

15- Filed MAR 1 - 1924 192.. Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 19 (Day) 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Conflagration by Illuminating Gas, Accident

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) James J. McAuliffe M. D. (Coroner.)

Mar 1 1924 (Address) 703 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, CONGRESINAL CEMETRY WASHINGTON DC — DATE OF BURIAL, MAR 4TH, 1924

20-UNDERTAKER ROBERT BROOKS & SON — ADDRESS COR CALHOUN HOLLINS ST

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84388

CERTIFICATE OF DEATH.

11-00 D 84388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 N. Calvert ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belva Pauline Holsinger

(a) RESIDENCE No. 1823 N. Calvert ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence B. Holsinger

6 DATE OF BIRTH (month, day, and year): Nov 4 1893

7 AGE — Years: 30 — Months: 3 — Days: 24 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md.

PARENTS

10 NAME OF FATHER: George F. Roghaller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hagerstown Md.

12 MAIDEN NAME OF MOTHER: Lillie V. Calbertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Md.

14 Informant: George F. Roghaller

(Address) 1823 N. Calvert St.

15 Robert P. Harrison, Registrar

Burial Permit Clerk

AR 1 -1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1924, to July 29, 1924, that I last saw her alive on July 28, 1924, and that death occurred, on the date stated above, at 2-45 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophy heart

Valvular insufficiency

(duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza and Bronchitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sound & Hand Chest X

(Signed) Francis D. McCarron M. D.

, 19 (Address) 416 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Thurmont Md

DATE OF BURIAL: March 2 1924

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 W North Ave

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84389

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

D 84389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1941 W. Mulberry St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hervey D. Spencer

(a) Residence No. 1941 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Nannie K. Spencer

6-DATE OF BIRTH (month, day and year) April 22 1863

7-AGE. 60 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ministry

9-BIRTHPLACE (city or town) (State or Country). Vermont

PARENTS.

10-NAME OF FATHER. David Spencer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Vermont

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Dont Know

14- (Informant) Mrs. Nannie K. Spencer

(Address) 1941 W. Mulberry St.

15- Robert P. Harrison,

Filed ..... 192.....

Registrar.

MAR 1 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 29/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 15/23 19.... to Feb 29/24 19....

that I last saw him alive on Feb 28/24 19....

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulonephritis

Pneumonia (Duration) 1 yrs. 1 mos. ds

CONTRIBUTORY (Secondary) Valvular Heart Disease

(Duration) 1 yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Holt, M. D

Feb 29 1924 (Address) 1303 Light

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Denton Curling Co. March 4 1924

DATE OF BURIAL.

20-UNDERTAKER, Jos Jacobsons Son

ADDRESS 2173 Pacca

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

169861 D 84390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X D 84390

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Robinson

(a) RESIDENCE NO. 131 N. Caroline Ave. Atlantic City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 11 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Cornelia Robinson

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel keeper

(b) General nature of industry, business, or establishment in which employed (or employer) " 080

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Del.

PARENTS

10 NAME OF FATHER Charles Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Alice Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Records JOHNS HOPKINS HOSPITAL. (Address)

15 MAR 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1924 to Mar 1, 1924 that I last saw him alive on Mar 1, 1924 and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder & Prostate with generalized Metastases. Bronchopneumonia.

(duration) yrs. 6 mos. or more ds.

CONTRIBUTORY (Secondary) Gall Stones, Cystitis, Pyelonephritis, Arteriosclerosis, Retention (duration) yrs. 6 mos. or more ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Charles Y. Bidgood, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia — DATE OF BURIAL Mar 5th 1924

20 UNDERTAKER Clarence E. Wm. Sch. — ADDRESS 364 Mary

mation should be carefully supplied. NOTE that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84391

CERTIFICATE OF DEATH.

D 84391

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1603 Belt St. ST.: 24 WARD)

2-FULL NAME Susan L. Williamson. 23.

(a) RESIDENCE. NO. 1603 Belt St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Williamson.

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73,		13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Calvin Williamson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah E. Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Thomas E. Williamson.
(Address) 1603 Belt St.

15 MAR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 24

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1913, to Feb. 29, 1924, that I last saw h. alive on Feb. 29, 1924, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) A. Behrend M. D.

Mar. 1 - 24, 19 (Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery.	March, 3, 1924.
20 UNDERTAKER	ADDRESS
A. Howard Evans.	1423 N. Charles St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84392

CERTIFICATE OF DEATH.

90 D 84392

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 N. Central Ave ST., 12 WARD)

2-FULL NAME Annie M. Buser

(a) RESIDENCE NO. 1035 N. Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Michael Buser

6 DATE OF BIRTH (month, day, and year): May 19 1854

7 AGE: Years 69 Months 9 Days 12 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Jorge Enchstradt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Maurer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss. Mary B. Buser

(Address): 1035 N. Central Ave

15 FILED MAR 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1923 to March 1 1924, that I last saw h alive on Feb 29th 1924, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Insufficiency Vascular Hemiplegia

(duration) 4 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Jones, M. D.

Mar 1 1924 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Mar 4 1924

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1611 E Eager St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84393

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 D 84393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3505 Elm Ave ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive L. Kemp

(a) RESIDENCE NO. 3505 Elm Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER William A Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Alice M Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant (Address) Mr Allen M. Kemp 3505 Elm Ave

15 MAR 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Feb 29, 1924, that I last saw her alive on Feb. 29, 1924, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Intermural fibroma Carcinoma (metastatic)

(duration) 1 yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 1922

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Vernon F Kelly, M. D.

Mar 1, 1924 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar. 3 1924
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fall Rd

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84394

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 84394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1313 Sycamore St., WARD 13)

2-FULL NAME Hilda M. Robert

(a) RESIDENCE No. 1313 Sycamore St. WARD 13
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 1920

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3	5	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS
10 NAME OF FATHER: Nelson M Robert
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City
12 MAIDEN NAME OF MOTHER: Rosie Lohr
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Nelson M Robert
(Address) 1313 Sycamore St

15 ROBERT R. KRAUTER, Registrar
MAR 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1924

17
I HEREBY CERTIFY, That I attended deceased from February 17 1924 to March 1 1924
that I last saw her alive on March 1 1924
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) C. H. Davies, M. D.
3-1, 1924 (Address) 3200 N 33rd St.

*State the Disense Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's, A.	Mar 3 1924
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Falls Rd

mation should be carefully supplied. Exact statement of OCCUPA-
it may be properly classified. CAUSE OF DEATH in plain terms, so that it
on back of certificates. TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1698 D 84395 — 1001 — X 143 — D 84395

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucretia Fay

(a) RESIDENCE NO. Jones Creek, Md. St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James Fay

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
32.	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER James J. Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 MAR 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1924, to March 1, 1924.

that I last saw her alive on March 1, 1924,

and that death occurred, on the date stated above, at 11 00 A.M.

The CAUSE OF DEATH* was as follows:

General peritonitis following Hysterectomy for Therapeutic abortion. Sought for Criminal

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) E. A. Bruce, M. D.

3/1, 1924 (Address) Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Maryland Balto Co — DATE OF BURIAL Mar 4 1924

20 UNDERTAKER W. C. Brooks — ADDRESS Sparks Md

mation should be carefully supplied. Exact statement of OCCUPATION should be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84396

CERTIFICATE OF DEATH.

1924 D 84396

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 N. Collington Ave ST., 6 WARD)

2-FULL NAME Samuel Sachs

(a) RESIDENCE NO 218 N. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer): 671
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Harry Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: John Lewis
(Address): 1439 E. Baltomore St

15 Filed: MAR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 29/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Probably Accidental

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Coltes, M. D.
(Coroner.)

March 4/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death....yrs., ...mos., ...ds. In the State....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rest Run

DATE OF BURIAL: 3/2 1924

20 UNDERTAKER: Jack Lewis 1439 E Balt St

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84397

CERTIFICATE OF DEATH.

161-001 ✓ D 84397

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 15 WARD)

2-FULL NAME Baby Boy Weiner

(a) RESIDENCE NO. 1702 Maryland Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/1/24

7 AGE Years ..... Months ..... Days 4-5-hours

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Mercy Hospital Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Weiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Deborah Sommekan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Records
(Address)

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/24 19

17 I HEREBY CERTIFY, That I attended deceased from 3/1/24, 19..... to 3/1/24, 19....., that I last saw he alive on 3/1/24, 19....., and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gallagher, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 3-2 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84398

CERTIFICATE OF DEATH.

41

D 84398

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E Monument ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Snyder

(a) RESIDENCE NO. 138 S. Eden ST ST., WARD Emergency Room

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 - 1908

7 AGE: Years 15 Months 9 Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Brook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to March 1, 1924 that I last saw him alive on March 1, 1924 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Infection of tonsil

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 2/25/24

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Howard M Kerr, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Cem Co

DATE OF BURIAL: 3/2 1924

20 UNDERTAKER: Jack Leidis

ADDRESS: 1439 E Balto

matter should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84399

CERTIFICATE OF DEATH.

1924 53 1872 129 D 84399

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Upton St ST., 17 WARD)

2-FULL NAME Martha Thomas

(a) RESIDENCE NO. 1201 Upton St ST., WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Thomas

6 DATE OF BIRTH (month, day, and year) Feb 22 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52.		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co. Md.

PARENTS

10 NAME OF FATHER William Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Edmonia Abeen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co.

14 Informant Laird Moore

(Address) 201 Upton St

15 Filed ..... 19.....

MAR 2 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1924

17

I HEREBY CERTIFY, That I attended deceased from 2/27, 1924, to 2/28, 1924.

that I last saw her alive on 2/28, 1924.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Interstitial)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) W. A. Harris, M. D.

, 19 (Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Mar 3rd 1924

20 UNDERTAKER Hammett & Wright — ADDRESS [illegible]

AGE should be stated EXACTLY. If under one year, state it in months and days. Information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84400

CERTIFICATE OF DEATH.

24 D 84400

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Providence Hospital WARD) 5

2-FULL NAME Jacob Fogaus

(a) RESIDENCE No. 1225 E Monument ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Fogaus

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 07°

(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura Fogaus (Address) 1225 E Monument St

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from 1/4, 1924 to Feb. 27, 1924.

that I last saw him alive on Feb. 27, 1924

and that death occurred, on the date stated above, at 6 1/2 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 4 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of —

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) Jno C. Robinson M. D.

3/28/24 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem.

DATE OF BURIAL 3/2 1924

20 UNDERTAKER Samuel Kinsley

ADDRESS 518 N Bridge St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84401

CERTIFICATE OF DEATH.

D 84401

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 7th St Fairfield ST. 25 WARD)

2-FULL NAME Elsie Shoubear

(a) RESIDENCE NO. 7th St Fairfield ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE. Years	Months	Days	If LESS than 1 day,.... hrs. or.....min.
30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): Housework also Miscarriage

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Hudgson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Lucy Stevens Fairfield Md

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/28 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22 1924 to July 28 1924

that I last saw him alive on July 27 1924

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, No Septic Pneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Miscarriage

(duration) — yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No Yes

What test confirmed diagnosis? Clinical

(Signed) N Kerr Dunger M. D.

, 19 (Address) 1340 E Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3/2 1924

20 UNDERTAKER: J Leon Hall

ADDRESS 753 Druid Hill Ave

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84402

D 84402

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Oakland ST. 27 WARD)

2-FULL NAME Frederick Brenner

(a) RESIDENCE. No. 6 Oakland ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Brenner

6 DATE OF BIRTH (month, day, and year) 15 July 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Section M E Church

(b) General nature of industry, business, or establishment in which employed (or employer) Hamdon 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Brenner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Hildefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Brenner

(Address) 6 Oakland st

Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 3 1924, to Feby 29, 1924

that I last saw him alive on Feby 28, 1924

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteris-Sclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

3/1, 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 3rd 1924
20 UNDERTAKER Isaiah Keyser 1600 Carswell Ave	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84403

CERTIFICATE OF DEATH.

1888 D 84403

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Carney

(a) RESIDENCE No 726 Poplar Grove St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Carney

6 DATE OF BIRTH (month, day, and year) Jan 31/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73		29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Bay View Hospital
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER C. W. Carney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Roxena Abell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Sadie Carney (Wife)
(Address) 726 Poplar Grove St

Burial permit issued
ROBERT R. KRAUTER,
Registrar

15 Filed MAR 2 - 1924 192
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull (Base) & rt. Femur
Hemo-Pneuno Thorax
(Autopsy at Hopkins

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Street Car Accident

Inquest to be held Mar 3 (duration) mos. ds.

(Signed) [signature], M. D.
(Coroner.)

Mar 1/24 192 (Address) 508 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Mar 4 192 4

20 UNDERTAKER Josiah Lepler — ADDRESS 1600 W North Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84404

CERTIFICATE OF DEATH.

31 D 84404

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S. Caroline St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel A. Testerman

(a) RESIDENCE NO. 126 S. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): not known

7 AGE: Years 17; Months —; Days —; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work 670

(b) General nature of industry, business, or establishment in which employed (or employer): house work

(c) Name of employer: Dentist.

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Peter C Testerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virgin Island W. Indies

12 MAIDEN NAME OF MOTHER: Mary Emilie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Peter C Testerman

(Address): 126 S. Caroline St

15 MAR 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Feb 28, 1924, that I last saw h[illegible] alive on Feb 27, 1924, and that death occurred, on the date stated above, at 12.30 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Richard E Erdman, M. D.

19 (Address) 1514 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: March 3 1924

20 UNDERTAKER: Mrs Edna F. Bailey

ADDRESS, 1721 Pennsylvania Ave

mation should be correctly supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84405

CERTIFICATE OF DEATH.

3/ D 84405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 735 S. Curley ST., 1 WARD)

2-FULL NAME Frank Mc Faul.

(a) RESIDENCE NO. 735 S. Curley St ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Mc Faul.

6 DATE OF BIRTH (month, day, and year) Dec. 19—1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Martin Mc Faul.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Anna Engberley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada.

14 Informant Anna Conyd. (Mother)

(Address) 735 S. Curley St

15

MAR 2 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29th 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to Feb 29, 1924, that I last saw h~~e~~r alive on Feb 29, 1924 and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Edocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Place of Work

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr. I. Burdine, M. D.

Mar 2, 1924 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL March 3 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St

AGE should be carefully supplied. Age at last birthday. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002 D 84406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 N. Lakewood Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar T. Backof

(a) RESIDENCE No 442 N. Lakewood Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	sinhle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 3/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓			27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick J. Backof

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Agnes Telljohann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Fred. J. Backof
(Address) 442 N. Lakewood Ave

15 Filed ... 192 ROBERT R. KRAUTER, Registrar
MAR 2 - 1924
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Congental Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. Waters, M. D.
(Coroner.)

Mar 1/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Mch 3 1924
20 UNDERTAKER Lilly & Fiala	ADDRESS 403 S Wolfe St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 84407

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 1 WARD)

2-FULL NAME Elizabeth Swinson

(a) RESIDENCE NO. 1710 S. Linwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William L. Swinson

6 DATE OF BIRTH (month, day, and year) Aug. 22 - 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35		7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Valentine Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Brigit Dunigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William L. Swinson

(Address) 710 S. Linwood ave

15 FILED MAR 2, 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-24, 1924, to 3-1, 1924, that I last saw her alive on 3-1, 1924, and that death occurred, on the date stated above, at 8 15 A m.

The CAUSE OF DEATH* was as follows:

Salpingitis

(duration) yrs. mos. over ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Feb 25, 1924

Was there an autopsy? Before Salpingectomy

What test confirmed diagnosis? Clinical Evidence

(Signed) J. Norwood Nelson M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Mch 5 1924

20 UNDERTAKER Lilly & Giles

ADDRESS 403 S. Wolfe St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Fuller

HEALTH DEPARTMENT---CITY OF BALTIMORE-001

D 84408

CERTIFICATE OF DEATH

10 D 84408

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1609 Lafayette St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella B. Fuller

(Residence in Baltimore: No. 1609 Lafayette St.; 23 yrs. 6 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female | 4-COLOR OR RACE Col. | 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married.

6-DATE OF BIRTH February 6 (Month) (Day) 1900 (Year)

7-AGE 23 yrs. 6 mos. 22 ds. | If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Paul Jenkins

11-BIRTHPLACE OF FATHER (State or country) South Carolina

12-MAIDEN NAME OF MOTHER Matilda Harris

13-BIRTHPLACE OF MOTHER (State or country) Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Fuller

(Address) 1609 Lafayette St.

MAR 2 - 1924

Filed ....., 191.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Feb. (Month) 28 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1924, to, Feb. 27 1924, that I saw h.e alive on Feb. 27 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cancer Pancreas,

about 2 mos.
(Duration) ..... yrs ..... mos. ..... ds,

Contributory (SECONDARY) Heart incompetency

(Duration) ..... yrs ..... mos. ..... ds.

(Signed), C. H. Frazer M. D.

....., 191.. [Address] 1216 Hanover St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Laurel Cemetery | DATE OF BURIAL Mar 2 1924

20-UNDERTAKER Wm R. C. Elliott | ADDRESS 1715 Ashland ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

TYPE

Spec.—1-10-21—M&T—1500 Blks.

Pabst

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84409

CERTIFICATE OF DEATH.

11-00 D 84409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 Edmondson Ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary J Mehring

(a) RESIDENCE NO. 1015 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Mehring.

6 DATE OF BIRTH (month, day, and year) June 6 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Pabst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary J. Pabst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Miss Emma L Pabst

(Address) 1015 Edmondson Ave

15 MAR 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb-24-1924 to Feb-29-1924 that I last saw h~~e~~ alive on Feb-29 1924 and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin W Shook M. D.

(Address) 8067 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Violetville — DATE OF BURIAL 3-2 1924

20 UNDERTAKER Wm Chas G Ronde — ADDRESS 100 N Carrington Ave

mation should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

b.

Cor.—1-12-23—M&T—100 Bks.

D 84410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84410

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 E. Weber St. ST., 24 WARD)

2-FULL NAME Vincent Rezac.

(a) RESIDENCE NO 118 E. Weber St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 35 yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, ~~or divorced~~ — HUSBAND of ~~(or) WIFE of~~ Frances Rezac.

6 DATE OF BIRTH (month, day, and year) August 15, 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charles Rezac (son).
(Address) Glen Burnie Maryland.

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M Leonhardt, M. D. (Coroner.)

March 1, 1924. (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A&Co — DATE OF BURIAL 3-3 1924

20 UNDERTAKER Chas B Hank — ADDRESS 115 E Weber St

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84411

CERTIFICATE OF DEATH.

16 V

D 84411

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 932 Chauncy ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Chana Berman

(a) Residence No. 932 Chauncy ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lazer Berman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 94 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto st

15- ROBERT R. KRAUTER,

Filed ..... 192.. Burial Permit Clerk.

MAR 2 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 2 1924.

17- I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to March 2, 1924, that I last saw h.. alive on March 2, 1924, and that death occurred, on the date stated above, at 2 10 p.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams M. D.

March 2, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Friendship Cem. DATE OF BURIAL, 3/2, 1924

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto st

To plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—I-12-23—M&T—100 Bks.

D 84412 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 ✓ D 84412

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 Ajax Alley ST., 10 WARD)

2-FULL NAME Howard I. Rogers

(a) RESIDENCE NO 743 Ajax Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 11/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Howard Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Md

12 MAIDEN NAME OF MOTHER Sarah Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Md.

14 Informant Sarah Rogers (Mother)
(Address)

MAR 7 - 1924 Burial Permit Clerk.

Registrar ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

.....(duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary) .....(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Paul (Coroner.), M. D.

Mar 1/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetary	Mar 5 1924
20 UNDERTAKER	ADDRESS
Jos. H. Rochester	1413 Jefferson St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Bjorn Eliasson.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84413

CERTIFICATE OF DEATH.

X 31

D 84413

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital, 4 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Bjorn Eliasson

(a) RESIDENCE NO. SS "Leif Jerson" ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 22 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27th 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 080

(b) General nature of industry, business, or establishment in which employed (or employer) Sailor

(c) Name of employer .....

9 BIRTHPLACE (city or town) Norway
(State or country)

PARENTS

10 NAME OF FATHER Andrew Eliasson

11 BIRTHPLACE OF FATHER (city or town) Norway
(State or country)

12 MAIDEN NAME OF MOTHER Anna Olsen

13 BIRTHPLACE OF MOTHER (city or town) Norway
(State or country)

14 Informant Hospital Record
(Address) Saratoga and Calvert Sts

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1/24 19

17 I HEREBY CERTIFY, That I attended deceased from 2/6/24, 19..., to 2/1/24, 19...,
that I last saw h~~e~~ alive on 2/1/24, 19... at 10 m.
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Chr. Pulmy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculosis Peritonitis

~~Intestinal~~ Obstruction (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No Blood

What test confirmed diagnosis? .....

(Signed) H. W. Hilley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL Feb. 3" 1924

20 UNDERTAKER Joseph L. Clark

ADDRESS 1003 W. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. If less than a day, the hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 84414

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 84414

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 12.)

2-FULL NAME Charles E. Varley-Myers

(Residence in Baltimore: No. 117 N. Carey Street St.; yrs. (6) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July 13 (Month) (Day) 1886 (Year)

7-AGE, 37 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Real Estate
(b) General nature of Industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Charles R. Varley-Myers

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Annie E. Tounes

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sally E. Varley Myers

(Address) 117 N. Carey Street

15-FILED MAR 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 28 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Angina Pectoris- Cardiac Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) Several weeks ds.

(Signed) J. S. M. Peters M. D.
(Coroner.)

2-29 1924 (Address) 505 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. March 3" 1924

20-UNDERTAKER. Geo. L. Boyle & Co. ADDRESS 1003 N. Eutaw St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84415

CERTIFICATE OF DEATH.

24 90

D 84415

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 Brevity St St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leroy Franklin Taylor

(a) Residence No. 103 Brevity St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 30 1900

7-AGE, 23 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or mtn.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Franklin P Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Catherine Jessel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14-

(Informant) Mrs C F Taylor

(Address) 103 Brevity St

15- MAR 2 - 1924 ROBERT L. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to Feb 1, 1924, that I last saw him alive on Feb 1, 1924, and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Chronic Valv Heart Dis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism Chronic

(Duration) 1 yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L J Burlingston, M. D.

, 19 (Address) 1028 Dorsa ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Md DATE OF BURIAL, Feb 27, 1924

20-UNDERTAKER. H Cook ADDRESS 501 E Ft Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84416

CERTIFICATE OF DEATH.

100 D 84416

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

2-FULL NAME Mary Hays

(a) RESIDENCE NO. 3527 Old York Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert W. Hays.

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 MAR 2 - 1924 ROBERT R. KRAUTER Registrar

Burial P 3

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-29 192X

17

I HEREBY CERTIFY, That I attended deceased from 12-11, 1923, to 2-29, 1924 that I last saw her alive on 2-28, 1924, and that death occurred, on the date stated above, at 2.45 9. m.

The CAUSE OF DEATH* was as follows:

Senile Detioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Brace, M. D.

2-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 3/3 1924

20 UNDERTAKER William Cook

ADDRESS 502 E. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. Information should be given as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84417 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84417

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer of Amer. Hospital WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin A. Haycock

(a) RESIDENCE. No. 1918 Madison Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Haycock

6 DATE OF BIRTH (month, day, and year) June 15, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dey

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo Haycock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Carrie Haycock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Margaret A Haycock.
(Address) 2800 Woodbrook Ave.

15 Filed MAR 2 - 1924 John R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1923, to Feb 28, 1924,
that I last saw him alive on Feb 28, 1924,
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Cardiac Decompensation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Passive Congestion of Lungs

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1918 Madison Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. R. Johnson, M. D.

2/27/1924 (Address) 1210 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 3 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

D 84418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Low STREET WARD)

2-FULL NAME Julia Hart

(a) RESIDENCE NO. 1001 Low ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Edward Hart

6 DATE OF BIRTH (month, day, and year): July 15 1877

7 AGE: Years 47; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: John Mallary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unkown

12 MAIDEN NAME OF MOTHER: Unkown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unkown

14 Informant: Edward Hart
(Address): 1001 Low Street

15 Filed MAR 2 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation due to
Illum Gas
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) M M Riley, M. D.
(Coroner)
March, 192 4 (Address) 16 34 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1001 Low Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hayden

DATE OF BURIAL: 3/3 1924

20 UNDERTAKER: William Cook

ADDRESS: 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 84419

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001V

D 84419

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lisbon Heights Resuscitation Co ST., WARD)

2-FULL NAME Robert A. Thorington

(a) RESIDENCE NO. 1136 Longwood ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Thorington

6 DATE OF BIRTH (month, day, and year) Oct. 21st 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frances A. Thorington

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Rote

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Ella Thorington
(Address) 1136 Longwood St

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

March 1, 1924 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury, Maryland — DATE OF BURIAL 3/3/24 192

20 UNDERTAKER H. E. Hughes, 424 No. Broadway — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D 84420

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3434 Edmondson St. 16 Ward)

2-FULL NAME Lucille Catherine Yeo

(a) RESIDENCE. No. 3434 Edmondson St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of child

6 DATE OF BIRTH (month, day, and year) June 30 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	~~June~~	~~30~~	
	3	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER W F Yeo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lockbodler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Wm F Yeo
(Address) 3434 Edmondson Ave

15 Filed ... 19 ... Robert K. KRAUTER, Registrar
MAR 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from July 1923 to March 1 1924

that I last saw h[er] alive on March 1 1924,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(duration) ... yrs. ... mos. 17 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Edward A Davis, M. D.

, 19 (Address) 2108 Brookfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 5 19
20 UNDERTAKER	ADDRESS
Jos L Gallo	1200 W Fayette

mation should be carefully supplied. Avoid abbreviations. Write plainly in ink. Statements should be typewritten. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 84421

CERTIFICATE OF DEATH.

D 84421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N. Broadway ST. 7 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meyer

(a) RESIDENCE NO. 826 N Broadway ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Meyer

6 DATE OF BIRTH (month, day, and year): May 13 1873

7 AGE — Years: 50 | Months: 9 | Days: | If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Theodore Bachmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helena Deitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: August Meyer
(Address): 826 N Broadway

15 MAR 2 - 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1924, to March 1, 1924, that I last saw her alive on Feb. 29, 1924, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Lessans, M. D.

3.1.24 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem | DATE OF BURIAL: Mar 4th 1924

20 UNDERTAKER: Geo M. Frank Son | ADDRESS: 811 N Mary

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spen.—6-9-19—H.P.Co.—1000 Bks.

D 84422

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84422

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1819 E Madison ST. 7 WARD.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura J. Jackson

(a) RESIDENCE. No. 1819 E. Madison ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James K.P. Jackson.

6 DATE OF BIRTH (month, day, and year): June 19-1845

7 AGE: Years 78 Months 9 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. City

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mary A. Vogel

(Address): 1723 N. Bradford St.

15 Filed MAR 2 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 1923. to March 2nd, 1924.

that I last saw her alive on March 1, 1924.

and that death occurred, on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 18 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Cystic Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John D. Teich M. D.

3/4 1924 (Address) 1936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Mar 6th 1924
20 UNDERTAKER	ADDRESS
Geo M. Frick & Son	834 W. Lex

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Austin -

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD Augusta, Ga.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Austin -

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Col	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Augusta - Ga

PARENTS

10 NAME OF FATHER Dr Girardy

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) France

12 MAIDEN NAME OF MOTHER (?) Not Known

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) (?)

14 Informant Records of Mt Hope Retreat (Address) Mount Hope Retreat -

15 MAR 2 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 7th 1924 to March 2 1924,

that I last saw h[illegible] alive on March 2 1924,

and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -

Col (duration) yrs. — mos. 1/2 ds.

CONTRIBUTORY (Secondary) Senile (Organic Nature) Psychosis

Col (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Augusta Ga

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Flournoy, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Augusta, Ga. DATE OF BURIAL March 19 24

20 UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84424

CERTIFICATE OF DEATH.

162 6

D 84424

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 213 N Duncan St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Berba

(a) Residence No. 213 N Duncan St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): Mar 1 1924

7-AGE. .....yrs.....mos.....ds. If LESS than 1 day, 5 hrs. or.....min.*

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Charles Berba

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Rose Shaer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Charles Berba
(Address) 213 N. Duncan St.

15- MAR 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 2 /24

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 st. 19 24 to Mar 2 19 24

that I last saw h[illegible] alive on Mar 1 19 24.

and that death occurred, on the date stated above, at 3 A .m.

The CAUSE OF DEATH* was as follows:

Asphyxia Hematoma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged Labor

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Mengel M. D

3/2, 19 24 (Address) 128 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Mar 3, 1924

20-UNDERTAKER. Paul Earnshaw — ADDRESS 1136 Eutaw

Should be carefully supplied. Exact statement of OCCUPATION is very important. See that it may be properly classified. in plain terms, so instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84425

CERTIFICATE OF DEATH.

129 D 84425

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Nth Gilmor ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph R. Smith

(a) RESIDENCE NO. 1037 Nth Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Smith

6 DATE OF BIRTH (month, day, and year) April 16-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of indnstry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisburg Pa

PARENTS

10 NAME OF FATHER Joseph R. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrisburg Pa

12 MAIDEN NAME OF MOTHER Carrie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co Md

14 Informant Robert F Smith (Address) 1037 N Gilmor

15 Filed MAR 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Feb. 29, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hamden — DATE OF BURIAL 3/3/24

20 UNDERTAKER Wm Cook — ADDRESS Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec— 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84426 90 D 84426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 113 W Lee St., 27 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominic LaRosa

(a) Residence No. 113 W Lee St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine LaRosa

6-DATE OF BIRTH (month, day and year) 1854

7-AGE	If LESS than 1 day,
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Frank LaRosa

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Jennie Lamaba

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Jennie Cuzzi

(Address) 113 W Lee St.

15- MAR 3 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-28-24

17- I HEREBY CERTIFY, That I attended deceased from 2-1 1924 to 2-28 1924

that I last saw h[illegible] alive on 2-27 1924

and that death occurred, on the date stated above, at 10 30 M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

2-29 1924 (Address) 810 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Rest Hebrew Cem.	March 3 1924
20-UNDERTAKER.	**ADDRESS**
F. A. Krauss & Son	703 Hanover St.

Should be carefully supplied. ALL blanks to be filled. Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84427.

CERTIFICATE OF DEATH.

129 D 84427

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2807 Simpson ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Jones

(a) RESIDENCE. No. 2807 S Simpson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Jones

6 DATE OF BIRTH (month, day, and year) Jan 10 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 400

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos L Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cordelia Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Annie Jones
(Address) 2807 Simpson

15 Filed MAR 3 - 1924, 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924, to March 1, 1924, that I last saw h.. alive on Feb 29, 1924, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sp. Kidney & Urine

(Signed) W Clyde Barnes, M. D.

3-1-24 (Address) 2012 2032

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	March 4 1924
20 UNDERTAKER Wm R A Elliott	ADDRESS 1725 Pulaski

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 84428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84428

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 100 S. Bouldin St. N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellwood A. Fisher

(a) Residence No. 100 S. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 15th 1923

7-AGE: ....yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: 0

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Chas. G. Fisher

11-BIRTHPLACE OF FATHER (city or town) (State or Country): City

12-MAIDEN NAME OF MOTHER: Margaret Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): N. C.

14-(Informant) Chas. G. Fisher

(Address) 100 S. Bouldin St.

15-

MAR 3 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 2-29-24.

17-I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to Feb 29, 1924, that I last saw him alive on Feb 29, 1924, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Schlieder, M. D.

3/2, 1924 (Address) 330 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL, 3/3/, 1924

20-UNDERTAKER: J. A. Moran ADDRESS 3000 E. Balto St.

Should be carefully supplied. Read instructions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84429

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1101 Sharp St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Lulu Coldwell

(a) Residence No. 1101 Sharp St., 23 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Caldwell

6-DATE OF BIRTH (month, day and year) December 27 1873

7-AGE, 50 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)... Steam Laundry

(c) Name of employer... Edmondson Laundry

9-BIRTHPLACE (city or town)... Rockville, (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, Moses Murray

11-BIRTHPLACE OF FATHER (city or town) Rockville, S. C. (State or Country),

12-MAIDEN NAME OF MOTHER, Laura Dixon

13-BIRTHPLACE OF MOTHER (city or town) Rockville (State or Country), S. C.

14-

(Informant)... Louise Muller

(Address)... 1101 Sharp St.

15-

Filed... 192... ROBERT R. KRAUTER, Registrar.

MAR 3 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 28th 24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 25th, 1924, to Feb. 28th, 1924, that I last saw her alive on Feb 28th, 1924 and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration)... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration)... yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of...

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) J. H. Hansell M. D.

2/1, 1924 (Address) 140 Orchard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Mch. 3 1924
20-UNDERTAKER.	ADDRESS
John H. Toadvine	142 Orchard

Should be carefully prepared so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84430

CERTIFICATE OF DEATH.

100-001 D 84430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hersh

(a) RESIDENCE NO. 2231 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced (or) WIFE of Alexander Hersh

6 DATE OF BIRTH (month, day, and year) Nov 18/1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER John Lander

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) Del (State or country)

14 Informant Municipal Hospital Records (Address)

MAR 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-13, 1923 to 2-29, 1924 that I last saw her alive on 2-29, 1924 and that death occurred, on the date stated above, at 2.50 P.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lot

(Signed) Claude S. Broad, M. D.

2-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk. Cem.	Mar. 3rd, 24
20 UNDERTAKER Philip Stenig	ADDRESS 2010 Eden St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

84431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

V 145 D003 84431

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 1 WARD)

2-FULL NAME Mrs. Agnes Virginia Hassell

(a) RESIDENCE NO. 734 S. Decker Ave ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Hassell

6 DATE OF BIRTH (month, day, and year) Sept. 24/886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas. Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Caroline —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frederick Hassell

(Address) 734 S. Decker Ave

15 Filed MAR 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1924, to Feb. 29, 1924, that I last saw h.e.r alive on Feb. 29, 1924, and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage & Shock incurred during operation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Laceration for extensive Lacerations following child birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? about 9 mo

Did an operation precede death? yes Date of Feb. 29, 1924

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) G. J. Goff M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Trinity — DATE OF BURIAL 3/3 1924

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84432

CERTIFICATE OF DEATH.

5 129 D 84432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314. N. Exeter ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) 1205 Mm

2-FULL NAME Joanna R. Andrews

(a) RESIDENCE NO. 314. N. Exeter ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? 59 yrs. mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White American

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Thomas B. Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Maryland

12 MAIDEN NAME OF MOTHER: Louisa J. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant: George W. Matthews

(Address) 314 N. Exeter St.

MAR 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20. 1924. to March 1. 1924. that I last saw h alive on March 1. 1924 and that death occurred, on the date stated above, at 12 05 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Nephritis

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation Failure Carpenter

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Daniel L. Ball, M. D.

, 19 (Address) 1516 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar 3 1924
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Carlton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84433

CERTIFICATE OF DEATH.

31 D 84433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Fisher

(a) RESIDENCE No. 130 S. Bethel st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5c If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James Alford

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Frances McCrae

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) U.T.H.

15 MAR 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1923, to Feb. 29, 1924, that I last saw her alive on Feb. 29, 1924, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally, M. D.

3-1-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL Mch 3 1924

20 UNDERTAKER L. E. Brown & Son — ADDRESS 118 N. Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

84434

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 84434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospl. ST., (ward A.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Meliszek

(a) RESIDENCE No. 1707 Fleet St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Meliszek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ——— ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Hospital Records.

15 Filed MAR 3 - 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1924, to Feb 29, 1924, that I last saw h~~im~~ alive on Feb 29, 1924, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Terminal pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lawrence Litt, M. D.

19 (Address) 1111 W. Fayrale St

(Postlight: Day Dur 10-30)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem.

DATE OF BURIAL 3/3 19 24

20 UNDERTAKER Great Eastern

ADDRESS 448 Bond

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84435

CERTIFICATE OF DEATH.

74-001 D 84435

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 359 N. Calvert ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ellen Amos

(a) RESIDENCE NO. 359 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hampden
(State or country) Md

PARENTS

10 NAME OF FATHER W. Amos.

11 BIRTHPLACE OF FATHER (city or town) Hampden
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Amos

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs M. Theis
(Address) 701 N Rayner

15 MAR 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

duration yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)
March 3, 1924 (Address) 1639 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethel Cem Kirkwood	March 4 1924
20 UNDERTAKER Jas Foerderer Son	ADDRESS 247 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--1-10-21--M&T--1500 Bks.

Debes.

D 84436 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84436

CERTIFICATE OF DEATH. 11-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1523 Ramsey ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Josephine Debes

(a) RESIDENCE NO. 152B Ramsay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Joseph M. Debes

6 DATE OF BIRTH (month, day, and year): Jany 8, 1877

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
47	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Benjamin Knell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Wilhelmina Sangmeister

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Miss Mary Debes

(Address) 1523 Ramsey St

15 Filed MAR 3 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 19, 1924, to Feby 29, 1924, that I last saw her alive on Feby 29, 1924, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary): La Grippe

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

3/11, 1924 (Address) 1081 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar 4 1924
20 UNDERTAKER	ADDRESS
Knell & Son	1729 W Balt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 84437

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Cummins

(a) RESIDENCE No. 2815 Gilsh Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Kissan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAR 3 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 - 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 6th, 19 23, to March 2nd, 19 24.

that I last saw him alive on March 2nd, 19 24.

and that death occurred, on the date stated above, at 12 15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(Acute exacerbation)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Otitis Media, Acute

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Conyers Taliaferro, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeph Shom — DATE OF BURIAL: 3/3 1924

20 UNDERTAKER: Joseph Lewis — ADDRESS: 1439 Eutaw

N.B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84438

CERTIFICATE OF DEATH.

162 D 84438

1-PLACE OF DEATH Sheltering Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., 5 WARD)

2-FULL NAME Baby Rosen

(a) RESIDENCE No. 1125 E Fayette ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 29, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel F. Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Breslin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel F. Rosen

(Address) 1125 E. Fayette St.

15 MAR 3 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 29, 1924, to March 1, 1924

that I last saw h[illegible] alive on March 1, 1924

and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) Isidor L. Jay, M. D.

Mar 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt. Carmel	3-3-1924

20 UNDERTAKER ... ADDRESS East Lewis 1131 E. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 84439

84439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Cook

(a) RESIDENCE NO. 924 Bevan St ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Dk Brown

11 BIRTHPLACE OF FATHER (City or town) Dk (State or country)

12 MAIDEN NAME OF MOTHER Dk Brown

13 BIRTHPLACE OF MOTHER (City or town) Dk (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed 19

MAR 3 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-16, 1924 to 2-28, 1924 that I last saw h[illegible] alive on 2-28, 1924 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, general + Cerebral

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude G Dyson, M. D.

2-29 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-3-1924

20 UNDERTAKER David Carlin

ADDRESS 916 Ba ave

N. B. [illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84440

CERTIFICATE OF DEATH.

D 84440

REGISTERED NO. 100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl F Wallett

(a) RESIDENCE NO. 2619 Bernard St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child 666

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Wallett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 MAR 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1924 to March 2, 1924.

that I last saw h— alive on March 2, 1924.

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(This was probably a streptococcic pneumonia)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Weed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL Mar 4 1924

20 UNDERTAKER CHENOWETH & SON — ADDRESS 3617 CHESTNUT AVE.

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84441

CERTIFICATE OF DEATH.

90 ✓ D 84441

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Bird ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth A. Maguire

(a) RESIDENCE NO. 621 Bird ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh. Maguire

6 DATE OF BIRTH (month, day, and year) Sept 8-1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	5	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Billger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr William H Maguire

(Address) 621 Bird St

15 Witness [illegible] ROBERT R. KRAUTER, Registrar.

1361 - CMW

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29th, 1924, to March 2nd, 1924, that I last saw her alive on March 1st, 1924, and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual methods

(Signed) L. D. Emmert, M. D.

(Address) 1929 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	March 5th 1924
20 UNDERTAKER Paul J. Cowen & Son	ADDRESS
P. J. Cowen & Son	617 Hollins

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 84442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84442

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2025 Rupp St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norris Elmore

(Residence in Baltimore: No. 2025 Rupp St.; 6 yrs. 3 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, Aug. (Month) 5 (Day) 1900 (Year)

7-AGE, 23 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Carriage Hdw Co

9-BIRTHPLACE, (State or Country), Crisfield, Md

PARENTS.

10-NAME OF FATHER, Thos. S. Elmore

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Alleta Duncan

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Thos S. Elmore

(Address) 2025 Rupp St.

15-

MAR 3 - 1924

ROBERT E. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 1 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot by gun-shot wound in head

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner)

March 2, 1924 (Address) 202 Edmondson Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Mar. 3, 1924

20-UNDERTAKER, Wm. J. McNamara ADDRESS North & Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84443

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84443

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2004 Robb St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Spamer

(a) Residence No. 2004 Robb St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. P. Spamer

6-DATE OF BIRTH (month, day and year) Aug 24 1886

7-AGE, 37 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Fred Eck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Christina Engel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Mr. Geo. P. Spamer

(Address) 2004 Robb St

MAR 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 29 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to Feb 29 1924 that I last saw h[illegible] alive on Feb 29 1924 and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. Hammerbacher M. D.

March 2 1924 (Address) 835 Lytle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Mar. 2. 1924
20-UNDERTAKER. Wm. Fichtner & Sons	ADDRESS. North & Pa

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A K S • S E T

Spec.—1-10-21—M&T—1500 Bks.

Trovell

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓

CERTIFICATE OF DEATH.

D 84444

REGISTERED NO. D 84444

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Swain Trovell

(a) RESIDENCE NO. Baldwin, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5g If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-27-24

7 AGE — Years — Months — Days — If LESS than 1 day, 1 hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James Trovell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Swain

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mother

(Address) JOHNS HOPKINS HOSPITAL

6 MAR 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk, 1180

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to Feb 26, 1924, that I last saw her alive on Feb 27, 1924, and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas Reese, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Mar 1 - 1924

19

20 UNDERTAKER Commissioner Health

Per Wm. E. Woodall

ADDRESS

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. DATE OF BIRTH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 155 D 84445

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Griffin

(a) RESIDENCE NO. 917 Watson ST., ... WARD ..... Balto. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Joe Griffin

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Jos Griffin
(Address) 917 Watson

15 MAR 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924, to March 1, 1924.

that I last saw h.. alive on March 1, 1924,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows: Osteomyelitis of femur

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Feb 21

Was there an autopsy? No

What test confirmed diagnosis? P. 3rs

(Signed) Harold E. Pillsbury M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Mar 3 1924

20 UNDERTAKER P B Goss — ADDRESS 1405 McElderry

N. B.—WHITE PENCIL, WHEN ORDERED, MUST BE USED. All items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Socki

D 84446 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84446

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 76 WARD)

2-FULL NAME Leonard Socki

(a) RESIDENCE NO. 3709 E. Pratt ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 4 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Socki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ana Koprorka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Lewicki
(Address) 2701 O'Donnell St

15 Filed MAR 3 - 1924 [illegible] Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1924, to March 1, 1924, that I last saw h/ alive on 3-1, 1924, and that death occurred, on the date stated above, at 8:00 A m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb. 28, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Norwood Wilson, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Mar 4 1924

20 UNDERTAKER Stephen J. Kiackowski ADDRESS 1100 S. Kenwood Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84447

CERTIFICATE OF DEATH.

90 D 84447

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1025 Vincent St. ST., 16 WARD)

2-FULL NAME Emma Brown

(a) RESIDENCE NO. 1025 Vincent St. ST., WARD

(Usual place of abode) about 65

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 65 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Kw. Dist. Police
(Address) Emma ave

15 Filed MAR 3 - 1924 1924 ROBERT R. KRAUTER Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coro (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. E. Kennedy, M. D.
(Coroner.)

Feb. 25 1924 (Address) 200 Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL S HOPKINS HOSPITAL.

DATE OF BURIAL MAR 3 1924

20 UNDERTAKER Commissioner Health,

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84448

CERTIFICATE OF DEATH.

101-001 ✓

D 84448

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Edmondson Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Amelie Louisa Ermold

(a) RESIDENCE. No. 712 Edmondson Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 11th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John. C. Ermold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Caroline Lucke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant John H. C. Ermold
(Address) 712 Edmondson Ave.

15 Filed MAR 3 - 1924 19

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1924, to Mch 2, 1924, that I last saw her alive on Mch 1—, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pleuro pneumonia,

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bernard Wood, M. D.

Mch 2, 1924 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Mch 1924
20 UNDERTAKER	ADDRESS 1039
E Schloman & Son	Hanover st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84449

CERTIFICATE OF DEATH.

14-001 ✓ D 84449

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 304 N. Mount St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Ella Carrington

(a) Residence No. 304 N. Mount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm Carrington

6-DATE OF BIRTH (month, day and year)

7-AGE, 60 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... House work
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Fincastle, Va.

PARENTS

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER, Ella King

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Fincastle, Va.

14-
(Informant)..... Hunter Carrington
(Address)..... 304 N. Mount St.

15- ROBERT R. KRAUTER,
Filed..... 192 Burial Permit Clerk and Registrar.

MAR 3 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 26th 1924 to March 1st 1924 that I last saw h[illegible] alive on Feb. 29th 1924 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Suddenly

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis* None

(Signed) C. L. Nicholls M. D.

, 19 (Address) 1305 S. Gilmor

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn DATE OF BURIAL. Mar 3 1924

20-UNDERTAKER, Bowers & Ludwig ADDRESS 114 N. Eutaw St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD MAKE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84450

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

CERTIFICATE OF DEATH.

D 84450
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1042 W Lexington St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Edward R. Cary

(Residence in Baltimore: No. 1042 W Lexington St.; yrs. 1 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. ... Jan (Month) 13 (Day) 1924 (Year)

7-AGE. ... yrs. 1 mos. 17 ds. If LESS than 1 day, ... hrs. or ... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)... 0

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Arthur Cary

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Hazel Francis

13-BIRTHPLACE OF MOTHER, (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Cary

(Address) 1042 W Lexington

15-

MAR 3 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March (Month) 2 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) James M Hanlon M. D. (Coroner.)

3-2-, 1924. (Address) 710 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Zion Cem	March 3, 1924

20-UNDERTAKER. Brown & Leland | ADDRESS 1405

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84451

CERTIFICATE OF DEATH.

31 D 84451

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hosp. ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Gentile (Anastatia)

(a) RESIDENCE NO. 4123 E. Lombard st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Phillips Gentile

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Riti

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Hospital Records
(Address) M.T.H.

15 Filed MAR 3 - 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1923, to March 1, 1924, that I last saw her alive on March 1, 1924, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lelly, M. D.

3-1-1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem DATE OF BURIAL 3/3/24

20 UNDERTAKER Gunning Bath ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 84452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84452

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Florence Crittenton Mission

CITY OF BALTIMORE: (No. 837 Hollins ST. 18 WARD)

REGISTERED NO. C 161-006

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Ann McCoy

(Residence in Baltimore: No. 837 Hollins St St.; ..... yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, February 6-1924, 1 (Month) 23 (Day) (Year)

7-AGE, ... yrs. ..... mos. 23 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... (None)
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Russel Hann

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Helen McCoy

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E. Gerber

(Address) 837 Hollins St.

15- Filed Mar. 1, 1924 ROBERT R. KRAUTER, Registrar.

MAR 3 - 1924 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 29 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 1924, to Feb 29 1924, that I saw h[illegible] alive on Feb 28 1924, and that death occurred, on the date stated above, at 4:25 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) Congenital Atelectasis.

(Duration) ..... yrs. ..... mos. 23 ds.

(Signed) Johnston Baldwin M. D.

Mar. ..., 1924 (Address) 1014 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery | DATE OF BURIAL, Mch. 3, 1924

20-UNDERTAKER Chas E. Franck | ADDRESS 802 Madison Av

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84453

CERTIFICATE OF DEATH.

90

D 84453

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 428 Kenneth Square Ward 25)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Charshee

(a) Residence No. 428 Kenneth Square Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Charshe

6-DATE OF BIRTH (month, day and year) Dec 25, 1853

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Harford Co. Md.

PARENTS

10-NAME OF FATHER, Bennett Charshee

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Harford Co Md.

12-MAIDEN NAME OF MOTHER, Kate W. Cook

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Harford Co Md.

14-Informant) Arthur T. Charshee

(Address) 334 E. University Pky.

15- Filed ..... 19.. Registrar. Robt P. Harrison

MAR 3 - 1924 Deputy Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 2. 24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 18th 1923, to March 2, 1924.

that I last saw h.m alive on March 1st 1924

and that death occurred, on the date stated above, at 10.30a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D

3/31. 1924 (Address) 3014 St Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL, March 4. 1924

20-UNDERTAKER John C. Mitchell — ADDRESS 1201 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84454 ✓ 129 D 84454

D 84454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 Riverside Ave ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Deaver

(a) RESIDENCE NO. 1145 Riverside Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Deaver

6 DATE OF BIRTH (month, day, and year) Nov. 2 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	83	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Deaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Catherine Jordan

(Address) 1145 Riverside Ave.

15 Filed ....., 19 Robert P. Harrison Registrar

R 3 - 1924 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1920, to Feb. 29, 1924.

that I last saw h m alive on Feb. 29, 1924.

and that death occurred, on the date stated above, at 2 A. M. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis about 5 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Hungary

What test confirmed diagnosis?

(Signed) C. P. Eckenbrath, M. D.

Mar 3 1924 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Mar 4 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should fill this out carefully and accurately. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 2-23-21—E.B.R.S.—400 Bks.

D 84455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1240 E. Monument St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Lewis

(a) Residence No. 1240 E. Monument St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Lewis.

6-DATE OF BIRTH (month, day and year): Nov 19 1859

7-AGE: 64 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of Industry, business, or establishment in which employed (or employer): P. R.R. Co
(c) Name of employer: U. S. Govt

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Geo R Lewis

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Anna Lutz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-INFORMANT: Hattie Lewis
(Address) 1240 E. Monument

15-Filed MAR 3 - 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 3/24

17- I HEREBY CERTIFY, That I attended deceased from Feby 26 1924 to Mar 3 1924

that I last saw him alive on Mar 2 1924

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1107 North Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Lowe M. D.

, 19 (Address) 1407 N. Carolina

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: May 7 19 24

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec— 2-23-21—E.B.R.S.—400 Blks.

D 84456 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 84456

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1304 N. Dallas St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Linton

(a) Residence No. 1304 N. Dallas St., Ward 8

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Robert Linton

6-DATE OF BIRTH (month, day and year): April 5. 1867

7-AGE: 56 yrs. 10 mos. 26 ds. If LESS than 1 day, ... hrs. or ~~... min.~~?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Dee

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Anna McKee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): John Dee
(Address): 1304 N. Dallas St.

15- Filed MAR 3 - 1924 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar. 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Decem. 12 - 1923 to March 2 - 1924

that I last saw h alive on March 2 - 1924

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov. 20-'24

Was there an autopsy? No

What test confirmed diagnosis? Every appearance

(Signed) Edwin B. Fenby, M. D

3/3/ 1924 (Address) 1223 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery. — DATE OF BURIAL: March 5, 1924

20-UNDERTAKER: George J. Ruth. — ADDRESS: 1735 Harford Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. ... instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84457

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Charles & Perry Sts.

CITY OF BALTIMORE: (No. Globe Brewery Garage ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Mc Mahon.

(a) RESIDENCE NO 310 E. Hamburg St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Annie Mc Mahon.

6 DATE OF BIRTH (month, day, and year) August 22, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	6	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work WATCHMAN
(b) General nature of industry, business, or establishment in which employed (or employer) Globe Brewery.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Michael McMahon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Annie Kane.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Raymond McMahon. (son).
(Address) 310 E. Hamburg Street.

15 Filed MAR 3 - 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns about the body.
from oil lantern.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Romano, M. D.
(Coroner.)

March 8, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs. ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	March 4 1924
20 UNDERTAKER	ADDRESS
C. A. Wiedefeld &	501 E 22 St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 84458

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 84458

Registered No.....

City of BALTIMORE: (No. 1429 East Hoffman St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Francis P. Cavanagh

(a) Residence No. 1429 East Hoffman St., St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa McKee

6-DATE OF BIRTH (month, day and year) ----------

7-AGE. 65 yrs. ? mos. ? ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchman

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Balto. City Water Dept.

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Peter Cavanagh

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Hanlon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Miss Ellen Cavanagh

(Address) 1429 E. Hoffman St.

15- FILED MAR 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 '24, 19.. to Mar 1 '24, 19.. that I last saw him alive on Mar. 1 '24, 19.. and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J H Saunders M. D.

3/3 19 24 (Address) 719 E. Preston St

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 3/4 1924 19....

20-UNDERTAKER W. Mears & Son

ADDRESS 805 Calvert St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84459

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 84459

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1200 N. Milton ave

CITY OF BALTIMORE: (No. 1200 N. Milton ave ST. 8 WARD) 4

2-FULL NAME Anna Marie Guier

(a) RESIDENCE NO. 1200 N. Milton ave ST. 8 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of G. Frank Guier

6 DATE OF BIRTH (month, day, and year) Nov. 18 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penn

PARENTS

10 NAME OF FATHER George F. Tillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Norcross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant G. Frank Guier (husband)
(Address) 1200 N. Milton ave

15 MAR 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to Feb. 29, 1924, that I last saw her alive on Feb. 29, 1924, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 11 mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma of the uterus

(duration) yrs. 11 mos. ... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Yes Date of April 25/1923

Was there an autopsy? No

What test confirmed diagnosis? (Wound and operation)

(Signed) A. L. Macdonald, M. D.

Feb 29, 1924 (Address) 1546 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	3/4 1924
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1938 E. Lafayette ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ANY ERROR OR OMISSION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84460

CERTIFICATE OF DEATH.

1132 D 84460

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 N Eldwood ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Miller

(a) RESIDENCE No. 114 W Eldwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER John J Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Nettie Yates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John J Miller

(Address) 114 W Eldwood

15 Filed MAR 4 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924, to March 3, 1924

that I last saw h— alive on March 2, 1924

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F Ohnmacht, M. D.

March 3, 1924 (Address) 35 N Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	March 4 1924
20 UNDERTAKER	ADDRESS
Kendall Supplee	370 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

84461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 E. Madison ST., 10 WARD)

REGISTERED NO. 111-09D 84461

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ellis

(a) RESIDENCE No. 1027 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Jeff Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Harriet Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Cornelia Ellis

(Address) 1027 E. madison St.

15 MAR 4 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29, 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1923 to Feb. 29, 1924, that I last saw him alive on Feb. 28, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastro intestinal catarrh

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. C. Robinson M. D.

3/3, 1924 (Address) 152 S. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar 4 1924
20 UNDERTAKER	ADDRESS
J. W. T. Rochester	1403 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 84462

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Earl Court Apts ST.: 11 WARD)

2-FULL NAME Edwin B Wayman

(a) RESIDENCE. No. Earl Court Apts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Lillian N. Wayman

6 DATE OF BIRTH (month, day, and year) Jan 27-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Work

(b) General nature of industry, business, or establishment in which employed (or employer) Automobile

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER John N. Wayman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill.

12 MAIDEN NAME OF MOTHER Catherine Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mimo.

14 Informant Lillian N. Wayman

(Address) Earl Court-apart

15 Filed MAR 4 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1924, to Mar 2nd 1924

that I last saw h~~im~~ alive on Feb 29 1924

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. W. Keen, M. D.

2-1, 1924 (Address) 6 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Chicago Ill DATE OF BURIAL Mch 4 1924

20 UNDERTAKER Chas E. Brandt ADDRESS 502 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84463

CERTIFICATE OF DEATH.

197 D 84463

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank L. Latham

(a) RESIDENCE No. 17 N. Belnord Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel D. Latham

6 DATE OF BIRTH (month, day, and year) July 16/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Patrolman
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Police
(c) Name of employer: Department

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Chas. L. Latham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Sophia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Ethel D. Latham
(Address): 17 N. Elnord Ave

15 MAR 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy [redacted].) thereon and from the evidence obtained by said inquiry (Inquest, autopsy [redacted].) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol shots in breast, shots fire d by Leo Schmidt, on Feb29/24

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Paul, M. D.
(Coroner.)

Mar 4/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Com — DATE OF BURIAL: Mar 6 1924

20 UNDERTAKER: Philip Herwig — ADDRESS 206 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84464

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 Richwood Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester R. Withers

(a) Residence No. 504 Richwood Ave St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Laura V. Withers

6-DATE OF BIRTH (month, day and year) Dec. 23rd 1854

7-AGE. 69 yrs. 2 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Vineyard Mass.

PARENTS.

10-NAME OF FATHER, Sylvester R. Withers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mass.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) Laura V. Withers

(Address) 504 Richwood Ave

15-

Filed MAR 4 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 3rd 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1924 to Mch 3 1924

that I last saw him alive on Mch 3 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urine test

(Signed) Jacob Fisher M. D

3/4 1924 (Address) 1823 Druid Hill Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Mar. 5th 1924

20-UNDERTAKER. Philip Davis ADDRESS 201 Orleans St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84465

CERTIFICATE OF DEATH.

59-002

D 84465

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 237 N 2nd St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kopperman

(a) Residence No. 237 N 2nd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 3/1924

7-AGE. ✓ yrs. mons. ds. If LESS than 1 day, 2 hrs. or.... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Bab

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Jno Kopperman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Denmark

12-MAIDEN NAME OF MOTHER, Carrie Satterfield

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Kopperman

(Address) 237 N 2nd

MAR 4 - 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4/24

17- I HEREBY CERTIFY, That I attended deceased from March 2 19 24 to March 4 19 24

that I last saw h. alive on March 3 19 24

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation (Cardiac)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

3/4, 1924 (Signed) H P Herzog MD M. D. (Address) 1305 N Patterson Pk

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Oak Lawn Cem	3/4/24
20-UNDERTAKER, John Ulrich	ADDRESS 298 Eden

N. B.—WHERE PERMIT, WITH FUNERAL NOTICE, IS REQUIRED, CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84466

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84466

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 111 N. Ann St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Franz

(a) Residence No. 111 N. Ann St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 2/24/1869

6-DATE OF BIRTH (month, day and year)

7-AGE. 05 yrs. — mos. 7 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of Industry, business, or establishment in which employed (or employer) 003
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Franz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Susanna Ebbeck

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-(Informant) Miss Caroline Franz

(Address) 111 N. Ann St

15-(Filed) MAR 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/2/1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 5 (.....) 1923 to Mch 2 1924

That I last saw him alive on Mch 1 1924

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical tests

(Signed) Leo Kelly, M. D.

3-3-1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 3/4, 1924

20-UNDERTAKER, John Ullrich ADDRESS 2908 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 84467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH March 1924

D 84467

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) No Pier Lady ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius C. F. Horstmann.

(a) RESIDENCE NO. 3103 Bilford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Horstmann

6 DATE OF BIRTH (month, day, and year) 7/27/1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73		5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mariner
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt E Horstmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Street

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ralph Horstmann
(Address) 3103 Sisson

15 Filed MAR 4 - 1924 ROBERT R. KRAUTER, Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 2. 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL 3/04/24

20 UNDERTAKER John Ellerin ADDRESS 208 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 34468

CERTIFICATE OF DEATH.

74-001

D 84468

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 616. Gilbert ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Johnson

(Residence in Baltimore: No. 616. Gilbert St.; 30 yrs.....mos.....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Unknown, 1869
(Month) (Day) (Year)

7-AGE, 55 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, ~~Thos Ellsin~~ Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Nancy —

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Mosley

(Address) 616 Gilbert St

15- MAR 4 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1924, to March 1 1924, that I saw h.r alive on Feb 29 1924, and that death occurred, on the date stated above, at 9a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia Paralysis

(Duration) yrs. 2 mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 2 mos.....ds.

(Signed) Mark H. Jones M. D.

March 2, 1924 (Address) 717 S. Wash St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn — DATE OF BURIAL, March, 1924

20-UNDERTAKER John F. Ehrenfried — ADDRESS 1100 Madison

Spec.-12-23-21—E.B.R.S.—400 Bks.

D 84469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 84469

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Simons

(a) Residence No. 235 Stricker st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1895

7-AGE: 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Thomas Simons

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Rosetta Martin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

11- (Informant): Hospital Records

(Address): M.T.H.

15- MAR 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 27 19 24 to March 3 19 24

that I last saw h. im alive on March 3 19 24

and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Terminal broncho-pneumonia (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally M. D

3-3-24 19 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3/5/24

20-UNDERTAKER: Daniel Easton ADDRESS: 916 Penna Ave

IN CASE OF DEATHS FROM VIOLENCE, PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84470

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 N. Stockton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bright

(a) Residence No. 6 N. Stockton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9m yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1866

7-AGE 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto City

(State or Country)

PARENTS.

10-NAME OF FATHER, John Bright

11-BIRTHPLACE OF FATHER (city or town)

(State or Country) Md

12-MAIDEN NAME OF MOTHER, Grace Bright

13-BIRTHPLACE OF MOTHER (city or town)

(State or Country) Md

14- (Informant) Mary Burgess

(Address) 6 N. Stockton St

15- MAR 4 - 1924

16- ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 1/24

17- I HEREBY CERTIFY, That I attended deceased from Feby 20, 1924, to Mar 1, 1924

that I last saw alive on Mar 1, 1924

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) — yrs. mos. — ds.

CONTRIBUTORY —

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Harry E. Wright, M. D.

3/4, 1924 (Address) 1056 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 3—4—, 1924

20-UNDERTAKER, Daniel Easton

ADDRESS 676 Pa Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84471

CERTIFICATE OF DEATH.

31 ✓

D 84471
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2936 Elliott St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Johanna F. H. Muhlenfeld.

(a) Residence No. 2936 Elliott St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George Muhlenfeld.

6-DATE OF BIRTH (month, day and year) June 25-1884

7-AGE. 39 yrs. 8 mos. 4 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. August Schlutter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Doris Jacobson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) George Muhlenfeld
(Address) 2936 Elliott St.

15-
Filed 192 ROBERT R. KRAUTER
MAR 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from July - 5 - 1923 to Feb 29 - 1924 that I last saw h. alive on Feb 26 - 1924 and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage - Pulmonary

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Jno. C. Bowers M. D.

19 (Address) 12 E. Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Mar. 4. 1924

20-UNDERTAKER. H. Sander & Sons

ADDRESS 1710 Fleet St.

L

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS TO BE FILLED IN. Spelling of Names should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Eks.

Dr Borden, 15-17 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84472

CERTIFICATE OF DEATH

1/101-001 D 84472

1-PLACE OF DEATH 328 East 21st Stud — Registered No.....

City of BALTIMORE: (No. ..... St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence W Schneider

(a) Residence No. 328 East 21st St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 25, 1906

7-AGE. 17 yrs. 7 mos. ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk 009
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer W. Cormack & Co

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS.
10-NAME OF FATHER, Wm C Schneider
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md
12-MAIDEN NAME OF MOTHER Louisa Christopher
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Mrs C L Christopher
(Address) 306 Norfod Road

15- Filed ..... 19.. ROBERT R. KRAUTER Registrar.

MAR 4 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from 2-28 19.24 to 3/2 19.24
that I last saw h[e] alive on 3/2 19.24
and that death occurred, on the date stated above, at 10[30] p.m.
The CAUSE OF DEATH* was as follows:

Right lobar pneumonia
(Central lung)

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

3/3 19.24 (Signed) Hal Borden M. D
(Address) 15-17 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, Mar 5 19.24

20-UNDERTAKER Wm Cook — ADDRESS 502 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—AND ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Friedmann 1013 N Charles St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84473 — 129 — D 84473

1-PLACE OF DEATH 432 East 23rd Street — 12 — Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice M Sapp

(a) Residence No. 432 East 23rd St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	W.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 27, 1895

7-AGE. 28 yrs. 9 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. William E Sapp

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Nellie T Whit

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14-
(Informant) Nellie T Sapp
(Address) 432 E 23 St

15-
MAR 4 - 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924 to March 2, 1924

that I last saw h. alive on March 2, 1924

and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Uremia Chronic Interstitial Nephritis Arteriosclerosis Hypertension about 3 yrs (Duration) 3 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis + Blood Urea

(Signed) Theodore H Thomson M. D

19 (Address) 1013 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Govans — DATE OF BURIAL. Mar 5, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Fath Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84474

CERTIFICATE OF DEATH. 129

D 84474

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Vincent ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jackson

(a) RESIDENCE No. 622 Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Jackson
(Address) 622 Vincent

MAR 4 - 1924

15 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1924, to Mar 2, 1924, that I last saw him alive on Mar 2, 1924, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey M. D.

3/3, 1924 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster, Md.	March 4 1924
20 UNDERTAKER	ADDRESS
Mrs James H. Dennis	1303 Freestman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84475

D 84475

CERTIFICATE OF DEATH.

REGISTERED No. C 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1124 Laurens St ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louella Chandler

(Residence in Baltimore: No. 1124 Laurens St

St.; yrs., 2 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. Dec 16, 1923
(Month) (Day) (Year)

7-AGE. yrs. 2 mos. 3 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). City

PARENTS

10-NAME OF FATHER. Robert Hill

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Lena Chandler

13-BIRTHPLACE OF MOTHER (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lena Chandler

(Address) 1124 Laurens St

15-

Filed ..... 191.... ROBERT B. KRAMER
Registrar.

MAR 4 - 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Hennessy M. D.
(Coroner.)

March 3 1924 (Address) 1780 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL
Mt Olivet	March 4, 1924

20-UNDERTAKER Clarence E. Wingfield ADDRESS 1614 N Ca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84476

CERTIFICATE OF DEATH.

90

D 84476

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2200 Morris St ..... St., 13 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Wilson

(Residence in Baltimore: No. 2200 Morris St ..... St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: C.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: July ..... (Month) ..... (Day) ..... 1861 (Year)

7-AGE: 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Balt Md

PARENTS.

10-NAME OF FATHER: J. Wilson

11-BIRTHPLACE OF FATHER, (State or Country): Balt Md

12-MAIDEN NAME OF MOTHER: Sallie Ruder

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Wilson

(Address) 1917 Druid Hill Ave

15-

Filed ..... 192 .....

ROBERT R. KRAMES

Registrar.

MAR 4 - 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: March ..... (Month) 1 (Day) ..... 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular disease of heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Williams M. D.
(Coroner.)

1924 (Address) 3672 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	March 4, 1924
20-UNDERTAKER,	ADDRESS
Mrs Jas H Dennis	1303 Pennsylvania Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84477 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84477.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 3155 Frederick Ave St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Deliah C Humphreys

(a) Residence No. 3155 Frederick Ave St. Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of David F Humphreys

6-DATE OF BIRTH (month, day and year) April 2 1855

7-AGE. 69 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Howard Co Md

PARENTS:
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Howard Co Md
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Howard Co Md

14-(Informant) Josephine Humphreys
(Address) 3155 Frederick Ave

15-Filed MAR 4 - 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 3/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1924 to March 3 1924 that I last saw h~~e~~ alive on March 3 1924 and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones M D

3.4. 1924 (Address) 722 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. March 5. 1924

20-UNDERTAKER. Wilhamberg ADDRESS 1526 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84478

CERTIFICATE OF DEATH.

74-001

74 D 84478

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702. N. Broadway ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Achsah Carpenter

(a) RESIDENCE NO. 702 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or ~~divorced~~ (or) WIFE of: Henry L. Carpenter

6 DATE OF BIRTH (month, day, and year): Apr 9 - 1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Smithfield Pa.

PARENTS

10 NAME OF FATHER: Wm. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Redstrake

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Clarence E. Carpenter

(Address): 702 N. Broadway

15 MAR 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/2/24 19

17 I HEREBY CERTIFY, That I attended deceased from Feby 29, 1924, to March 2, 1924, that I last saw h[illegible] alive on March 2, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Nonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alf L. Gay, M. D.

3/3/24 (Address) 1704 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: March 4 1924

20 UNDERTAKER: Robt J. Turner Son

ADDRESS: 1942 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK-SAFETY FILM

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 84479

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 Sargent St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura - V - Lantz

(a) Residence No. 1111 Sargent St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Lantz

6-DATE OF BIRTH (month, day and year) March 16-1858

7-AGE 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Thos. B. Wheatley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER Lordy Wheatley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Louis Lantz

(Address) 1111 Sargeant

15-

MAR 4 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/3/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924, to March 3, 1924, that I last saw her alive on March 3, 1924 and that death occurred, on the date stated above, at 1-P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ..... yrs. ..... mos. 12 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis?

(Signed) Robert Dreier, M. D.

, 19 (Address) 727 Madison Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. The Carroll Cathy

DATE OF BURIAL, March 6, 1924

20-UNDERTAKER, Wm Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84480

CERTIFICATE OF DEATH.

90

D 84480

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 W. Lanvale ST. 17 WARD)

2-FULL NAME James ~~Henry~~ Henry Thomas

(a) RESIDENCE NO. 711 W. Lanvale ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred about 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Thomas

6 DATE OF BIRTH (month, day, and year) Jan 1, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	71	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 086

(b) General nature of industry, business, or establishment in which employed (or employer) in office building

(c) Name of employer Gaither Estate

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont Know

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont Know

14 Informant Blanche Holliday (Address) 711 Lanvale St

15 Filed MAR 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to Mar 3, 1924, that I last saw him alive on Mar 2, 1924, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

aortic stenosis

several years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation + incompetent valves about
(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) A. E. Krumpp, M. D.

3/3, 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. — DATE OF BURIAL 3-6 1924

20 UNDERTAKER George T. Gibson — ADDRESS 1735 Harlem

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D 84481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Ettwig ST., 14 WARD)

2-FULL NAME Viola Jenkins

(a) RESIDENCE NO. 1823 Ettwig ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) —

6 DATE OF BIRTH (month, day, and year) Dec 2, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph C Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Mahammitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs Saddie West 1823 Ettwig st.

15 Filed MAR 4 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1923, to March 2, 1924, that I last saw h alive on March 1, 1924, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Mucous Colitis &
Occassional Hemmorrhage

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

19 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	3-6 1924
20 UNDERTAKER George T. A. Gibson	ADDRESS 1726 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84482

CERTIFICATE OF DEATH.

D 84482

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2006 Poplar Grove St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Teresa Bokee

(a) Residence No. 2006 Poplar Grove St., ... Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? 66 yrs. 4 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) October 28 1857

7-AGE, 66 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired.

(c) Name of employer Retired.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. F. Bokee

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Mc Crane

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland.

14-

(Informant) Mr Robt. J. Colmus

(Address) 1730 Eliamont St.

MAR 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 2 1924

17- I HEREBY CERTIFY, That I attended deceased from March 20th, 1924, to Mar 2nd, 1924

that I last saw h.. alive on March 2nd, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

.....(Duration).....yrs.....mos....7....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Isaac C. Dickson, M. D.

Mar 3rd 1924 (Address) 3055 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Mar 5 1924

20-UNDERTAKER, STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN in plain terms, so that it may be properly classified. Exact statement of OCI instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84483

D 84483

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Arundel Apts St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry Stabler Reese

(a) Residence No. Arundel Apts St., 11 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? 73 yrs. 9 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Belle Reese

6-DATE OF BIRTH (month, day and year) May 9-1850

7-AGE. 73 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer). " "

(c) Name of employer. " "

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Thos. M. Reese

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Rockville Maryland

12-MAIDEN NAME OF MOTHER. Martha Stabler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Sandy Spring Maryland

14-

(Informant) Messrs Reese (Sons)

(Address) Arundel Apts

15-

MAR 4 - 1924

ROBERT R. KRAUTER,

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to Mar. 1, 1924, that I last saw him alive on Mar. 1, 1924, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Irene C. Clark, M. D.

Mar 2, 1924 (Address) Catonsville Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Burying Ground

DATE OF BURIAL, Mar 4, 1924

20-UNDERTAKER. STEUART & McGUIRE COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO
should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
In plain terms, so that it may be properly classified. Exact statement of OCCU
instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84484

100-001

CERTIFICATE OF DEATH.

D 84484
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sibley Sanatorium ST., 19 WARD)

2-FULL NAME Dietrich J. Harries

(a) RESIDENCE NO. 440 E. Gilmore ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Harries

6 DATE OF BIRTH (month, day, and year) June 21. 1848

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery Store
(b) General nature of industry, business, or establishment in which employed (or employer) 034
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER John Harries
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Sophia Zeibshe
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katharine Harries
(Address) 440 E. Gilmore St

15 MAR 4 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1923 to Mar. 3, 1924
that I last saw h im alive on 1924
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? If

What test confirmed diagnosis? Clinical

(Signed) Edw V Coalter, M. D.

3/4/24 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 5. 1924

20 UNDERTAKER ADDRESS
Mr. Mrs. J. W. Teufel & Son 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

84485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84485

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2575 W Fayett St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thomas P Walsh

(Residence in Baltimore: No. 2575 W Fayett St.; 36 yrs., 8 mos., 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Mal

4-COLOR OR RACE, Whit

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Dec (Month) 26 (Day) 1867 (Year)

7-AGE, 54 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of Industry, business, or establishment in which employed (or employer) Emerson Drug Co

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, John Walsh

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Sarah McKew

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Walsh

(Address) 2575 W Fayette St

15- MAR 4 - 1924

Filed....., 192.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 3 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H Kelso M. D. (Coroner.)

3, 3, 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, March 6 1924

20-UNDERTAKER, John F Cowan & Son ADDRESS, 411 Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WHITE UNPRINTED INK.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84486

CERTIFICATE OF DEATH.

129 D 84486

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 932 Lemmon St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Joseph T. Sullum

(a) Residence No. 932 Lemmon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 7th 1845

7-AGE,	If LESS than 1 day,
78 yrs. 8 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Retired Mer

(b) General nature of industry, business, or establishment in which employed (or employer)... last 30 yrs

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Sullum

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-

(Informant)... Mrs. Frank Sullum

(Address)... 932 Lemmon St

15-

Filed MAR 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 3 1924.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to March 3, 1924,

that I last saw h— alive on March 3, 1924,

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY —
(Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine Exam.

3/3/24. (Signed) J. Chas Norton, M. D.

(Address) 888 W. Lombard St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem	Mar 5 1924

20-UNDERTAKER.	ADDRESS
John T. Howard Son	901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84487

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84487

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4238 Parkheights ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy E. Grove

(Residence in Baltimore: No. 4238 Parkheights ave St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced. (Write the word.): S

6-DATE OF BIRTH: Oct (Month) 26 (Day) 1923 (Year)

7-AGE: ... yrs. 4 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country): Balt Md

PARENTS.

10-NAME OF FATHER: Ralph Grove

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Emily Williams

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph E Grove

(Address) 4238 Parkheights ave

15- Filed ... 192.. ROBERT R. KRAUTER, Registrar.

MAR 4 - 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 2 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Emil Hausdorf M. D. (Coroner.)

Mar 3 1924 (Address) 3632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Western Cem DATE OF BURIAL, Mar 4th 1924

20-UNDERTAKER: Leo G. Cook ADDRESS 2018 Hartford

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84488

CERTIFICATE OF DEATH.

10-001 ✓ D 84488

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 900 WOODBOURNE AVE St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JEROME A. WALSH

(a) Residence No. 900 WOODBOURNE AVE St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. MALE

4-COLOR OR RACE, WHITE

5-Single, Married, Widowed, or Divorced, (Write the word.) SINGLE

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) MARCH 20, 1897

7-AGE. 26 yrs. 11 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work CLERK

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) BALTIMORE MD

PARENTS.

10-NAME OF FATHER, JOHN J. WALSH

11-BIRTHPLACE OF FATHER (city or town) (State or Country) BALTIMORE, MD

12-MAIDEN NAME OF MOTHER, M. KATIE HOLDEN

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) BALTIMORE, MD

14- (Informant) JOHN J. WALSH

(Address) 900 WOODBOURNE AVE

15- Filed MAR 4 - 1924 Robert F. Harrison, Registrar.

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 2. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 22 1924 to March 2 1924

that I last saw him alive on March 2 1924

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia (Lobar)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. M. Duncan M. D.

March 2, 1924 (Address) 5106 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. CATHEDRAL CEMETERY. DATE OF BURIAL. 3/5 1924

20-UNDERTAKER H. W. MEARS & SON-505 N. ADDRESS CALVERT ST

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84489

CERTIFICATE OF DEATH.

D 84489

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ortbee

(a) RESIDENCE NO. Bay View Asylum ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE: Years 70 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Reno

(Address)

15 Filed MAR 4 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 1 19 24

17 I HEREBY CERTIFY, That I attended deceased from 2 - 27 1924 to 3 - 1, 1924.

that I last saw h alive on 3 - 1, 1924

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Left

(Signed) Claude S. Grace, M. D.

3-3 1924 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health, — ADDRESS MAR 4 1924

Rev. Wm. A. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of tube mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T.—1500 Blks. (Edward)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84490

CERTIFICATE OF DEATH.

D 84490

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Municipal Hospital ST. 76 WARD)

2-FULL NAME Edward E. Parks

(a) RESIDENCE NO. Bay View Asylum ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records (Address)

15 Filed MAR 4 - 1924 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 3-2 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-20 1924 to 3-2 1924

that I last saw him alive on 3-2 1924

and that death occurred, on the date stated above, at 1.55 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic myocarditis

Myocardial failure (duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude B. Dorsey, M. D.

3-3 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, ADDRESS 1924

MAR 4 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84491 ✓ 31 D 84491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 Arlington Av ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrie Gaines

(a) RESIDENCE NO. 233 Arlington Av ST WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6- '06

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer mill

(c) Name of employer Standard Fertilizer Mill

9 BIRTHPLACE (city or town) (State or country) Anderson S. C.

PARENTS

10 NAME OF FATHER Willis Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anderson S.C.

12 MAIDEN NAME OF MOTHER Eula James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anderson S.C.

14 Informant (Address) Mother 233 Arlington Ave

15 Filed MAR 4 - 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4- 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/16/ 1924 to 3/4/ 1924, that I last saw him alive on 3/3/ 1924, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia — Lobar

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. L. Jackson M. D.

19 (Address) 804 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS 19

Commissioner Health.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 84492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84492

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3514 Fall Rd St. 13 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry D. Rhoades

(Residence in Baltimore: No. 3519 Fall Road St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Divorced

6-DATE OF BIRTH, May 15, 1872
(Month) (Day) (Year)

7-AGE, 51 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Frederick W. Rhoades

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary E. Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. Miller

(Address) 3519 Fall Road

15-

Filed ..... 1924 Robt. F. Harrison, Registrar.

MAR 4 - 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 3, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy, or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner.)

Mar 3, 1924 (Address) 3632 Belvidere

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Cemetery	Mar 5, 1924

20-UNDERTAKER	ADDRESS
A.S. Marshall	3539 Fall Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Nbs.

D 84493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3332 Chestnut Ave ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Griffith

(a) RESIDENCE NO. 3337 Chestnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Bertha V. Griffith

6 DATE OF BIRTH (month, day, and year) Mar 2 1854

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: James S Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Sarah Whitehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Mrs Lillie Griffith

(Address) 3332 Chestnut Ave

15 Filed MAR 4 1924, 19 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1923, to Mar 2, 1924, that I last saw h[illegible] alive on Mar 1, 1924, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davis, M. D.

(Address) 500 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys

DATE OF BURIAL: Mar 6 19 24

20 UNDERTAKER: A S Maskall

ADDRESS: 3539 Fall Rd

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84494

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME H. Isaac Brown

(Residence in Baltimore: No. Texas Balto Co Md St.; yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	White	Single

6-DATE OF BIRTH. Feb. 18 (Month) (Day) 1906 (Year)

7-AGE. 18 yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Veneer factory

9-BIRTHPLACE, (State or Country). Balto. Co. Md.

PARENTS.

10-NAME OF FATHER. Isaac N. Brown

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Co. Md.

12-MAIDEN NAME OF MOTHER. Florence N. Cox

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Union Mem. Hospital

(Address) Colvert & 33rd

15- MAR 4 1924 Albert F. Harrison, 19.. Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 3 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second degree burns

Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Louis Kessler M. D. (Coroner.)

1924 (Address) 3632 Boston

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Poplar Balto Co DATE OF BURIAL. Mar 5 1924

20-UNDERTAKER. W C Brooks ADDRESS. Dundalk Md

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84495

CERTIFICATE OF DEATH

134 D 84495

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33 st ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Dotterweich

(a) RESIDENCE No. 345 S. Clinton st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Andrew Dotterweich

6 DATE OF BIRTH (month, day, and year) Sept 27, 1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fish & Crab dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Pete Dotterweich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant The Patient.

(Address)

15 MAR 4 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1924, to March 3, 1924, that I last saw h alive on March 3, 1924, and that death occurred, on the date stated above, at 9.55 Am.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Cystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Examination

(Signed) Donald C Chandler, M. D.

3/3, 1924 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Mch. 6 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84496

CERTIFICATE OF DEATH.

45 D 84496

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Thirteenth ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Christina Gross

(Residence in Baltimore: No. 318 S. Thirteenth St St.; Life yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 25, 1874
(Month) (Day) (Year)

7-AGE, 49 yrs. 9 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Harris.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Caroline Wagner.

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Larkin (Son)

(Address) 318 S. 13th St.

15-

Filed MAR 4 - 1924, 19..

Robert P. Harrison.
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 2, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 10 1923, to March 2 1924, that I saw h.. alive on March 1 1924, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Gallstones

Cardiac Embolism

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

(Signed) Maxwell L. Mason M. D.

March 3, 1924 (Address) 315 E. Balt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cem.

DATE OF BURIAL, March 5, 1924

20-UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84497

90D 84497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital. St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Wheeler.

(a) Residence No. 329 N. Lexington St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. ds. How long in U. S., if of foreign birth? 9/12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 82. yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do not know

12-MAIDEN NAME OF MOTHER, Do not Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

11- (Informant) Mrs. Howard French.

(Address) 329 N. Lexington

15- Filed MAR 4 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4 24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 28 1924, to March 4 1924, that I last saw h.. alive on March 4 1924, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency.

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. Goldenberg, M. D

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL. 3-5-, 1924

20-UNDERTAKER, Robert Brooks & Son

ADDRESS Calhoun & Hollins sts

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 120 N Durham ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casper J Falkenhan

(a) RESIDENCE. No. 120 N. Durham ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widwd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Casper Falkenhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER E. Mary Downs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Casper Falkenhan

(Address) 120 N Durham St

15 Filed MAR 4 - 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 19, 1924, to Mch 3, 1924, that I last saw him alive on Mch 3, 1924, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

Exhaustion Bronchitis

Fair (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sequelae of Broncho pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Robertson, M. D.

, 19 (Address) 717 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem Mch 5	19 24
20 UNDERTAKER	ADDRESS
Eichen & Feralkowski	1005 S Hanover

MARGIN RESERVED FOR BINDING

15.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D 84499

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 734 E 21 St ST. 9 WARD)

2-FULL NAME Josephine Crawford Maynard

(a) RESIDENCE NO. 734 E 21 St ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W Maynard

6 DATE OF BIRTH (month, day, and year) Dec 13 1837

7 AGE: Years 86 | Months 2 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Isaac Smith
(Address) 734 E 21 St

15 Filed MAR 4 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26. 1924, to Feb 3 1924.
That I last saw h e alive on Feb 3 1924,
and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:
Cholecystitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No,

What test confirmed diagnosis? Clinical

(Signed) John A Evans M. D.

, 19 (Address) 10 N Eutaw,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem | DATE OF BURIAL: March 5 1924

20 UNDERTAKER GRENOWETH & SON, | ADDRESS 3617 CHESTNUT AVE

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84500 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84500

CERTIFICATE OF DEATH.

13 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Tudor Hall Apartments St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Elias Latimer

(a) Residence No. Tudor Hall Apartments St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Lord Latimer

6-DATE OF BIRTH (month, day and year) June 23, 1848

7-AGE. 75 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer). Furniture

(c) Name of employer. Manufacturer

9-BIRTHPLACE (city or town)...Utica (State or Country), New York

PARENTS.

10-NAME OF FATHER, Robert Latimer

11-BIRTHPLACE OF FATHER (city or town). Utica (State or Country), New York

12-MAIDEN NAME OF MOTHER, Maria Hyatt

13-BIRTHPLACE OF MOTHER (city or town). Utica (State or Country), New York

14: (Informant). George W. Latimer

(Address). Tudor Hall Apartments

15:

Filed ..... Robert P. Harrison, Registrar.

MAR 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from March, 19 22 to March 3, 19 24 that I last saw h.. alive on March 3, 19 24 and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. M. Dill M. D.

3-4, 1924 (Address) 2425 Maryland Avenue

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Utica, New York	Mar. 6" 24
20-UNDERTAKER. Joseph L. B. Cook	ADDRESS 1003 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84501

CERTIFICATE OF DEATH.

Registered No. C. 170

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnus Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Amail Gustav Theodore Leydecker

(Residence in Baltimore: No. 2923 Frederick Avenue St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. November 5 (Month) (Day) 1860 (Year)

7-AGE, 63 yrs. 3 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

9-BIRTHPLACE, (State or Country) Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, A.G.Theodore Leydecker

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Herder

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Annie Leydecker
(Address) 2923 Frederick Ave.

15- Filed 192.. Robert P. Harrison, Registrar.

MAR 4 - 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gun shot wound below the heart
Self Inflicted Incid
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) James M Bruce M. D. (Coroner)
3-3 192.. (Address) 709 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death [illegible] yrs. mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Surgeons Hall Bath

Former or usual residence 2923 Frederick Ave

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem DATE OF BURIAL, March 6 192.

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Eutaw St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84502

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2758 Robison ST., 1 WARD)

2-FULL NAME Frank Comi

(a) RESIDENCE No. 2758 Robison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emila Comi

6 DATE OF BIRTH (month, day, and year) December 22 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 044

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Comi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Ruffall Santo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Louis Comi

(Address) 1401 S Clinton

15 Filed MAR 4 - 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1924, to March 3, 1924,

that I last saw him alive on March 2, 1924

and that death occurred, on the date stated above, at 12¼ P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Pennington, M. D.

3.4.24, 19 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 5 1924
20 UNDERTAKER	ADDRESS
Wendell Coppel & Son	370 Mon

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84503

CERTIFICATE OF DEATH.

101-001 ✓ D 84503

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 222. N. Gilmor ST. 19 WARD)

2-FULL NAME Daniel Vaughn

(a) RESIDENCE No. 222. N. Gilmor ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Nannie Vaughn

6 DATE OF BIRTH (month, day, and year) Oct - 186

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard Vaughn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Serena Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Minnie R. Vaughn

(Address) 222. N. Gilmor

15 Filed MAR 4 - 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 D 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1924, to March 2, 1924, that I last saw him alive on March 2, 1924, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

and Endocarditis

(duration) yrs. 1 mos 19 ds.

CONTRIBUTORY (Secondary) Pneumonia

& Endocarditis (duration) yrs. ? mos. 19 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Fred Dale, M. D.

, 19 (Address) 1926 E 22 ward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL March 5, 1924

20 UNDERTAKER Sam'l H Chase & Son — ADDRESS 1400 Madison

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

MAR 4 - 1924

Spec.—1-10-21—M&T—1500 Bks.

D 84504 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 84504

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 626 Redwood ST., 4 WARD)

2-FULL NAME Wm E. Moore

(a) RESIDENCE No. 626 Redwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): ~~Aug 31-23~~ 8-31-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	~~Aug 31-23~~	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo E Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Mary Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Mary Alice Moore 626 Redwood

15 MAR 4 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from March 3 - 1924, to March 3 - 1924, that I last saw him alive on March 3 - 1924, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. H. Coleman M. D.

(Address) 2539 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: March 5 1924

20 UNDERTAKER: Wm. H. Chase Sons — ADDRESS: 1400 Mosher

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84505

CERTIFICATE OF DEATH.

D 84505

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Mason

(a) Residence No. 2127 Hollins st. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widow Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1868

7-AGE. 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Thomas Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Carrie ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-Informant: Hospital Records

(Address): M.T.H.

15-Filed MAR 4 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 16 19 24 to March 4 19 24

that I last saw h. alive on March 4 19 24

and that death occurred, on the date stated above, at 6.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. C. Kelly M. D

3-4- , 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Loudon Park	March 7 24
20-UNDERTAKER.	ADDRESS
William Beck	532 E Pratt

3—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84506

CERTIFICATE OF DEATH.

161-9 84506

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1706 Thames Ave ST. 15 WARD)

2-FULL NAME Hilda Siesel

3-(a) RESIDENCE. No. 1706 Thames ST., — WARD. —

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
♀	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-3-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Oliver B Siesel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hilda Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Oliver Siesel (Address)

15 Filed ....., 19.. Robert P. Harrison Registrar

Burial Permit #[illegible]

MAR 4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 — 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1924, to Mar 4, 1924, that I last saw her alive on Mar 3, 1924, and that death occurred, on the date stated above, at — 11 A m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

(Address) 2702 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 5 1924

20 UNDERTAKER ADDRESS

Williams Cal 502 E Balto

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84507

CERTIFICATE OF DEATH

D 84507

REGISTERED NO. 1005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Rabey St ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Lye

(a) RESIDENCE NO. 819 Rabey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 65 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colred

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10-1923

7 AGE: Years — Months: 2 — Days: 23 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Chas Lye

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ethel Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ethel Lye (Address) 819 Rabey St

15 Filed: MAR 5 - 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY That I attended deceased from March 2. 1924 to March 3. 1924. that I last saw him alive on March 3. 1924. and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr E W Kemsarg M. D.

3-4. 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Mch 5 1924

20 UNDERTAKER: John H Toadvine — ADDRESS 142 Ostend St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may CAUSE OF DEATH in plain terms, so should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Tillman

(a) Residence No. 506 W. Lee St

(Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown 1874

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Carolina Wilson

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-

(Informant) Mrs Campbell

(Address) 506 W Lee St

15-FILED MAR 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 15 1923 to March 3 1924, that I last saw her alive on March 3 1924, and that death occurred, on the date stated above, at 8-10 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Epithelioma of lip - general metastasis - & Cachexia.)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Wm. J. Fulton, M. D

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Auburn	Mch. 5 19 24
20-UNDERTAKER, John H. Toadvine	ADDRESS 142 Argyle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONS RESPONSIBLE FOR BURIAL

Cor.—1-12-23—M&T—100 Bks.

D 84509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D 84509

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Munn

(a) RESIDENCE No. E 5328 Hamlin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29 1853

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ret. Ship. Carpt
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Edward F Callahan
(Address) 2815 Baltimore Ave

15 MAR 5 - 1924
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia Following fracture of Femur Caused by auto accident Feb 15-'24

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.

March 5, 1924 (Address) (Coroner.) 639 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs., 2 mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL March 5 1924

20 UNDERTAKER H H Witzke

ADDRESS Lombard & Gilmor st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84510

100-001

100 D 84510

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

2-FULL NAME Melvin Klawansky

(a) RESIDENCE NO. 108 Augusta ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 21-1923

7 AGE — Years: 4 — Months: 4 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Annie Gorozick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 MAR 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 11 - 1924 to Mar 4 1924.

that I last saw him alive on Mar 4 - 1924.

and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

Microcephaly

(duration) ..... yrs. life mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 25 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. A. Weech, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Orphans Home

DATE OF BURIAL: March 5 19 24

20 UNDERTAKER: Jos. T. Levin

ADDRESS: 39 E. Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84511
1-PLACE OF DEATH

31 D 84511
REGISTERED NO.

CITY OF BALTIMORE: (No. 1118 N Linwood Ave 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C McGuire

(a) RESIDENCE. No. 1118 N. Linwood Ave WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~nee, WIFE of~~ Margt McGuire

6 DATE OF BIRTH (month, day, and year) Feb 15 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48 yrs.		16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Storekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) Infirmary
(c) Name of employer Balto Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Daughter
(Address) 1118 N Linwood Ave

MAR 5 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1924 to Mar 2 1924, that I last saw h~~im~~ alive on Mar 2 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

?

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) —

.....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam

(Signed) Wm Ozell, M. D.

, 19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Co.	Mar 5 1924
20 UNDERTAKER Philip Hennig	ADDRESS 2016 Orleans St

AKS

Spec.—8-24-14—M. & T.—2000 Bks.

D 84512

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84512

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Eutaw Pl. ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Boyd Mules

(Residence in Baltimore: No. 1602 Eutaw Place St.; 63 yrs., mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH. February 28, 1861.
(Month) (Day) (Year)

7-AGE, 63 yrs. mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Linotype Setter
(b) General nature of industry, business, or establishment in which employed (or employer): 063

9-BIRTHPLACE, (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Thomas Henry Mules

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Mary Jenkins

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William B. B. Mules

(Address) 310 W. Fayette St.

MAR 5 - 1924 ROBERT A. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 3, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11, 1921, to Mch 3, 1924, that I saw him alive on Mch 1, 1924, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation

(Duration) 1 yrs. mos. several ds.

(Signed) Ino A Kutscher M. D.

March 4, 1924 (Address) 1025 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	March 5, 1924.
20-UNDERTAKER	ADDRESS
George J Smith	Hollins

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84513

CERTIFICATE OF DEATH.

101-001

D 84513

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia J. Dawes

(a) Residence No. 1004 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ?

7-AGE	If LESS than 1 day
70 ? yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant) Municipal Hospital Records

(Address)

15- MAR 5 - 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-3-24

17- I HEREBY CERTIFY, That I attended deceased from 2-29, 1924 to 3-3, 1924

that I last saw her alive on 3-3, 1924

and that death occurred, on the date stated above, at 12 05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude C. Dawes M. D

3-3, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Carmel Cemetery	Mar 5th 1924
20-UNDERTAKER,	ADDRESS
Johnnie Landers	1008 Aisquith St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Cager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 84514

REGISTERED NO. D 84514

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Morris ST., 11 WARD)

2-FULL NAME Jennie Cager

(a) RESIDENCE NO. 938 Morris ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of George Cager

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer Balt. City

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. Lizzie Cager 938 Morris St.

15 MAR 5 - 1924 ROBERT [redacted]AUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1923 to March 2nd, 1924 that I last saw h. alive on March 1st, 1924 and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 9 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence 938 Morris

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Elliott, M. D.

3-2, 1924 (Address) 924 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Mar 5 1924

20 UNDERTAKER	ADDRESS
Mrs. R. L. Elliott	1725 Eastland

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84515

CERTIFICATE OF DEATH.

101-001 D 84515

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 339 W Preston ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lee -

(a) RESIDENCE. No. 339 W Preston ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb 27 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53 -		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Marie Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. R. C. Elliott 1225 Eastland ave

15 MAR 5 - 1924 ROBERT M. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to Mch 2, 1924, that I last saw h- alive on Mch 2d, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Congestion Hemp. Heart Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 5 1924
20 UNDERTAKER	ADDRESS
Mrs R C Elliott	1225 Eastland ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 84516

D 84516

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 W Conway ST., 7 W WARD)

2-FULL NAME Eugene L Brown

(a) RESIDENCE NO. 538 W Conway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany — 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Sugar Refinery

(c) Name of employer American Sugar Refining Co

9 BIRTHPLACE (city or town) (State or country) Chestertown Maryland

PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chestertown Md

12 MAIDEN NAME OF MOTHER Julia Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chestertown

14 Informant Sadie Elsie
(Address) 521 N Conway St

15 Filed MAR 5 - 1924 ROBERT M. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from February 26, 1924, to March 3, 1924, that I last saw him alive on March 2d, 1924, and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) Hemitis and Cardiac weakness (duration) — yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? Det Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E Mackenzie, M. D.

Mch 4 1924 (Address) 1339 N North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	March 1924

20 UNDERTAKER Mrs. R.G. Elliott ADDRESS 720 Eastland Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Srec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84517

CERTIFICATE OF DEATH.

117

D 84517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Stricker ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harris Allen

(a) RESIDENCE. NO. 218 N. Stricker ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 yrs	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country) U. S.

PARENTS

10 NAME OF FATHER Benjamin Allen

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) U. S.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown. (State or country)

14 Informant Sophia Allen. (Address) 218 N. Stricker St.

15 [illegible]

MAR 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1923 to Mch 4, 1924, that I last saw h[illegible] alive on Mch 3, 1924, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Peritonitis.
Patient was a degenerate
I never revealed his illness

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Probably ruptured Appendix (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Myers, M. D.

, 19 (Address) 1271 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	March 7th 1924
20 UNDERTAKER John F. Fielder	ADDRESS 1600 W. Lombard St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84518

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Roborg ST., 18 WARD)

2-FULL NAME George Smith

(a) RESIDENCE NO. 1209 Roborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Smith

6 DATE OF BIRTH (month, day, and year): March 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Water Department

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Peter Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Phillis Friends

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Ida Smith

(Address): 1209 Roborg St

15 Date received MAR 5 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1924, to March 2, 1924

that I last saw him alive on March 2, 1924

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Intersticial Nephritis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James M Harper, M. D.

3/3, 1924 (Address) 213 N. Fulmore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: 3/5 1924

20 UNDERTAKER: Edward Wheeler ADDRESS: Fulton

Spec.—1-30-21 M&T 1500 Blks.

D 84519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 114 Altona Ave ST., 27 (WARD)

2-FULL NAME Mary Jane Ohnson

(a) RESIDENCE NO. 114 Altona Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas M Ohnson

6 DATE OF BIRTH (month, day, and year) May 25 1855

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
68	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Edward Hyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Lizzie Hyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Ada Freeman

(Address) 114 Altona Ave

15 Filed MAR 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1924, to March 5, 1924.

that I last saw h alive on March 4, 1924,

and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? ——

(Signed) Morris B Green, M. D.

3/5, 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nuture of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 3/8/24

20 UNDERTAKER: Edmund Louis — ADDRESS: Hilltop

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84520

CERTIFICATE OF DEATH.

37 D 84520

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Gwynn Falls Pkway St.) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Leon Wisenbaker

(Residence in Baltimore: No. 3913 Gwynn Falls Parkway St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. Dec 12, 1923
(Month) (Day) (Year)

7-AGE. 10 yrs. 2 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. James Leon Wisenbaker

11-BIRTHPLACE OF FATHER (State or Country). Georgia

12-MAIDEN NAME OF MOTHER. Louise Morgan

13-BIRTHPLACE OF MOTHER (State or Country). Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis L Wisenbaker

(Address) 3913 Gwynn Falls Pkwy

15- Filed MAR 5 1924 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 5, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 27 1924, to March 5 1924, that I saw him alive on March 4 1924, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculer Meningitis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis degeneration

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Howard T. Warner M. D.

Mar. 5, 1924 (Address) 2604 Towson Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Gray Georgia

DATE OF BURIAL. Mar. 12 1924

20-UNDERTAKER H. Dawson Sons

ADDRESS Myrtle Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84521

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3823 Dalrymple Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D. Hammerbacher

(a) Residence No. 3823 Dalrymple Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cora M. Hammerbacher

6-DATE OF BIRTH (month, day and year) Feb. 7 - 1889

7-AGE. 35 yrs. mos. 23 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Candy Mfg

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. George Hammerbacher

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Ortmiller

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Germany.

14- (Informant) Cora M. Hammerbacher

(Address) 3823 Dalrymple Ave

15- FILED MAR 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 25 - 1924 to March 2 1924

that I last saw h. alive on March 2 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Sx & Symptoms

(Signed) Thomas J. Klutz M. D.

, 19 (Address) 401 E. 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cem.	Mar 6., 19 24
20-UNDERTAKER.	ADDRESS
Josiah Pfeffer	1600 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84522

HEALTH DEPARTMENT—CITY OF BALTIMORE.

46 D 84522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 North Fulton ST., 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Hafele

(a) RESIDENCE No. 2106 N. Fulton Ave., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of the late John Hafele

6 DATE OF BIRTH (month, day, and year) Sept 2-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	69	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Brooklyn New York

PARENTS

10 NAME OF FATHER Geo. Bichmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosina Mohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter R. Meyer (Address) 210 N. Fulton ave

15 Filed MAR 5 - 1924, 19.....

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3" 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany. ....., 1924. to Mar. 2" ....., 1924.

that I last saw her alive on Mar. 2" ....., 1924.

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Uterine carcinoma

.....(duration) 1 yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary) X

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? Yes Date of Oct., 1923.

What test confirmed diagnosis? Exploratory, Removal impossible. Microscope.

(Signed) O. H. Hofmann, M. D.

3/4, 1924 (Address) 3462 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/6/24

20 UNDERTAKER Geo. Weber & Son 2503

ADDRESS Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PREPARED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 95 3 84523 — D 84523

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 1 WARD)

2-FULL NAME Jacob Eder

(a) RESIDENCE NO. North Pt. Road ST., Was Co WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1900-?

7 AGE: Years 24 | Months ? | Days ? | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: William Eder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Eliz Kapus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: JOHNS HOPKINS HOSPITAL

(Address)

MAR 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1924, to March 3, 1924, that I last saw h in alive on March 3, 1924, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis, right ureteral calculus and pyelonephrosis ? at least a year

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of about two weeks ago

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Winfield W. Duff, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: March 6, 24

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84524 CERTIFICATE OF DEATH. 38 D 84524

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Stokes

(a) RESIDENCE No. 1337 Stockton St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) about 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	78 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Colonial Hosp.
(Address) Monument St.

MAR 5 - 1924 ROBERT R. KRAUTER,
..... 192 Registrar
Burial Permit Clerk.

70 1193

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dyspnea

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

March 7, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Mar 3 1924

20 UNDERTAKER Commissioner of Health,

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84525 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 84525

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Conner

(a) Residence No. 800 N. Central St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruby Conner

6-DATE OF BIRTH (month, day and year): 1865

7-AGE: 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS.

10-NAME OF FATHER: James Conner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-(Informant): Municipal Hospital Records

(Address):

15-

MAR 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-3-24

17: I HEREBY CERTIFY, That I attended deceased from 3-3-24, 19.. to 3-3, 19.24

that I last saw him alive on 3-3, 19.24

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

Myocardial Insufficiency

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Drane, M. D

3-4, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oakdale Cemetery — DATE OF BURIAL: 3/7/1924

20-UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84526

CERTIFICATE OF DEATH.

90

D 84526

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., No WARD)

2-FULL NAME Willis Bruce

(a) RESIDENCE NO. Not Known ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	b-	not Known

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 6 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed MAR 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to Eco death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) 2 yrs. mos. ds.

(Signed) Geo Claudius Ward, M. D.
(Coroner)
Mar 4 '24 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL MAR 5 - 1924

20 UNDERTAKER Commissioner Health. — ADDRESS

66

NOTE—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84527

CERTIFICATE OF DEATH.

118-002

D 84527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Egrad Baer

(a) RESIDENCE NO. 1523 Park Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25 - 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Simon Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Moyed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Simon Baer

(Address) 1523 Park Ave

MAR 5 - 1924 ROBERT M. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1924, to March 4, 1924, that I last saw h[illegible] alive on March 4, 1924, and that death occurred, on the date stated above, at 11.20 P.M.

The CAUSE OF DEATH* was as follows: Appendicitis Chronic

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar 4-24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible] M. D.

3/4, 1924 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kehren Washington Bd.

DATE OF BURIAL 3/5 1924

20 UNDERTAKER Jack Lenks 1439 E Balto

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-11-Bs-M-Ty-10 Bks.

D 84528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84528

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Etting St. ST., 14 WARD)

2-FULL NAME Thos. Young

(a) RESIDENCE No. 1710 Etting St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colred	widowed

5a If married, widowed, or divorced
HUSBAND of unknown
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer (General)

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Thos. E. Nelson
(Address) 515 Eutaw St.

15 Filed APR 5 - 1924, 192 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. E. Hennessy, M. D.
(Coroner.)

March 24, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Mar. 5 1924

20 UNDERTAKER: Mrs James H Dennis — ADDRESS: 1303 Freestown St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 84529

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3029 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy T. Teehley

(a) Residence No. 3029 Elliott St., 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 20th 1864

7-AGE. 59 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): A.A.C. Co.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Co.

PARENTS.

10-NAME OF FATHER: Timothy Teehley.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Tracey.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Mary Teehley.

(Address): 831 S. Third.

15- MAR 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch. 3rd/24

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1924 to March 3, 1924

that I last saw him alive on March 3, 1924

and that death occurred, on the date stated above, at 10 20/a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronuslaw M. D

3-3-24 (Address) 3037 Odonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	Mch. 6th 1924
20-UNDERTAKER. Lilly + Zeiler	ADDRESS 4038 Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Krysiak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84530

CERTIFICATE OF DEATH.

129 D 84530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 S Ann ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rosie Krysiaks

(a) RESIDENCE No. 620 S Ann ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephan Krysiaks

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Stefanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Mary Wisniewska Daughter

(Address) 6 S Spring Sparrows Point Md

MAR 5 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/29, 1924, to 3/3, 1924, that I last saw him alive on 3/3, 1924, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis, Arteriosclerosis, Broncho Pneumonia

(duration) yrs. mos 4 7 ds.

CONTRIBUTORY (Secondary) Heart failure & asthenia

(duration) yrs. mos. 3 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay B Rutherford, M. D.

3/3/, 1924 (Address) 1625 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus,	March 6 1924.
20 UNDERTAKER M. J. Sadowski	ADDRESS 405 S. Ann

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84531

CERTIFICATE OF DEATH.

124 D 84531

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

2-FULL NAME Mr. Luther Calvin Read

(a) RESIDENCE NO. 552 W. University Parkway - City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of Mrs L C. Read - (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67		9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturing Agent

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va -

PARENTS

10 NAME OF FATHER Littleton Read

11 BIRTHPLACE OF FATHER (city or town) Va - (State or country)

12 MAIDEN NAME OF MOTHER Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) Va - (State or country)

14 Informant Mrs L. C. Read

(Address) 552 University Parkway

MAR 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 29, 1924, to Mar 4, 1924, that I last saw him alive on Mar. 4, 1924, and that death occurred, on the date stated above, at 12 45 p m.

The CAUSE OF DEATH* was as follows:

Perforated Gall Bladder

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb. 29, 24

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Harold R. Ballman, M. D.

, 19 (Address) Union memorial hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Mar 6 1924
20 UNDERTAKER	ADDRESS
Henry J Jenkins Sons Co	Orchard & Collok

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 84532

CERTIFICATE OF DEATH.

D 84532

91-0021

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH Roland Park

CITY OF BALTIMORE: (No. 4 Englewood Rd ST., 77 WARD)

2 FULL NAME Eleanor Addison Brogden

(a) RESIDENCE NO. 4 Englewood Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of James McCulloh Brogden

6 DATE OF BIRTH (month, day, and year) 1837-8-11

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) ~~Name of employer~~

PARENTS

9 BIRTHPLACE (city or town) (State or country) Long Green Balto Co Md.

10 NAME OF FATHER James Gilling o

11 BIRTHPLACE OF FATHER (city or town) (State or country) Long Green Md.

12 MAIDEN NAME OF MOTHER Rebecca H. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John F Brogden

(Address) Calvert & Redwood

15 Filed MAR 5 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1924 to Mar 2nd, 1924.

that I last saw her alive on March 2nd, 1924.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Uremia - Sclerosis

(General or Cerebral)

(1st Symptoms about 10 yrs ago)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions & Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) Wm F. Luckenbach M.D.

3/5 1924 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem. Long Green Md.

DATE OF BURIAL 3-6 1924

20 UNDERTAKER H. W. Jenkins & Son Co

ADDRESS Mt Washington Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 ✓

D 84533

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Conwell

(Residence in Baltimore: No. 2023 Maryland Ave St.; (yrs. 80) mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

6-DATE OF BIRTH. December 20 1840
(Month) (Day) (Year)

7-AGE. 83 yrs. 2 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lady.
(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9-BIRTHPLACE, (State or Country). Leesburg Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Allen R. Van Meter

(Address) Phila Pa.

15-

Filed MAR 5 - 1924 192..

ROBERT R. KRAUTER
Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 4 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion brain
pulmonary shock
accidentally struck by auto
(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.
(Coroner.)

March 5 1924 (Address) 1639 Ward

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. 3-6 1924

20-UNDERTAKER. Hennegan Jenkins & Son Co — ADDRESS 2116 Ulloh & Orchard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84534

CERTIFICATE OF DEATH.

90 D 84534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6206 Oak Lane ST., Cedarcroft WARD)

2-FULL NAME Elizabeth Helen Walker

(a) RESIDENCE NO. 6206 Oak Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years about 65 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Henry Sawyer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Brunner

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Bessie Walker (Address) 6202 Oak Lane

15 Filed MAR 5 1924 ROBERT R. KRAUTER Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924.

17 I HEREBY CERTIFY, That I attended deceased from February, 1922, to March 4, 1924, that I last saw her alive on March 3, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Ke[illegible] Mayer, M. D.

March 7, 1924 (Address) 2458 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL March 6 1924

20 UNDERTAKER J. W. Jenkins & Co — ADDRESS Eutaw & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84535

CERTIFICATE OF DEATH.

90 D 84535

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Joseph Ritka

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed MAR 5 1924, 19 Registrar

ROBERT A. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 1 1924

17

I HEREBY CERTIFY, That I attended deceased from 8-14, 1923, to 3 - 1, 1924

that I last saw him alive on 3 - 1, 1924

and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Chronic Myocarditis

Myocardial insufficiency

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub

(Signed) Claude A. Hance, M. D.

3-1, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Lookout. DATE OF BURIAL 3/6/1924

20 UNDERTAKER J. J. Fahey, Jans. ADDRESS 1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mc Heal.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84536

100 D 84536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH House of Good Shepherd

CITY OF BALTIMORE: (No. Fremont & Hollins ST. 19 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary St Vincent Carmel

(a) RESIDENCE. NO. Fremont & Hollins st. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of the Good Shepherd

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) County Roscommon Ireland

PARENTS

10 NAME OF FATHER Patrick Mc Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister of the Good Shepherd

(Address) Fremont & Hollins st

15 Filed ....., 19[illegible] ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1924, to March 3rd, 1924, that I last saw her alive on March 3rd, 1924, and that death occurred, on the date stated above, at 7 00 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. K. Bland, M. D.

March 4th, 1924 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
House of Good Shepherd -	3/5/24 19
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84537

CERTIFICATE OF DEATH.

X143 D 84537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So Balto Gen'l Hosp. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MRS ELVA E. DOING.

(a) RESIDENCE NO. LINTHICUM HEIGHTS MD. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	MARRIED

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of CHARLES H. DOING

6 DATE OF BIRTH (month, day, and year) Oct 19 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MARYLAND.

PARENTS

10 NAME OF FATHER THOMAS O DUVALL

11 BIRTHPLACE OF FATHER (city or town) (State or country) MARYLAND

12 MAIDEN NAME OF MOTHER NORAH KELLY

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MARYLAND

11 Informant CHARLES H. DOING. (Address) LINTHICUM HEIGHTS MD

15 MAR 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1924

17

I HEREBY CERTIFY, That I attended deceased from FEB 18, 1924, to MARCH 4, 1924, that I last saw h~~er~~ alive on MARCH 4, 1924 and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

ACUTE CARDIAC DILATATION

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) RUPTURED ECTOPIC PREGNANCY

(duration) yrs. mos. 36 ds.

18 Where was disease contracted if not at place of death? HOME

Did an operation precede death? YES Date of

Was there an autopsy? ~~No~~ Yes

What test confirmed diagnosis? CLINICAL SIGNS & SYMPTOMS

(Signed) John A. Timmes M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/6/24
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1318 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

120°C

D 84538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-001

D 84538

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1300 N. Calvert St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas A. Whelan

(a) Residence No. 1300 N. Calvert St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Campbell

6-DATE OF BIRTH (month, day and year) Oct. 14, 1854

7-AGE, 69 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. President

(b) General nature of industry, business, or establishment in which employed (or employer). Fidelity Trust

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Thomas Whelan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Mary Duvall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland

14- (Informant) Thomas A. Whelan Jr.
(Address) 5 Norwood Place, Guilford

15-

Filed MAR 5 - 1924 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 4th 1924

17- I HEREBY CERTIFY, That I attended deceased from March, 19 24 to March 4th 19 24

that I last saw h.... alive on March 4th 19 24

and that death occurred, on the date stated above, at 11:50 A.m.

The CAUSE OF DEATH* was as follows:

Anemia, Adenoid Ca (Retro Peritoneal) (6 mos)

Co., (Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis,

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical symptoms

(Signed) Jos. Chatard M.D.

Mar 5 1924 (Address) 49 W. Read St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery — DATE OF BURIAL. 3/6 1924

20-UNDERTAKER. Henry W. Mears & Son — ADDRESS 805 N. Calvert

Burial [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84539

CERTIFICATE OF DEATH.

D 84539

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2106 Dobler Ave ST.: 8 WARD

2-FULL NAME William Francis Frick

(a) RESIDENCE. No. 2106 Dobler ave ST. WARD. 9

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2/1923

7 AGE — Years: — Months: 6 Days: 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edward Frick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary F Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mr Edward Frick

(Address): 2106 Dobler Ave

15 Filed MAR 5 - 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY That I attended deceased from March 4, 1924 to March 4, 1924, that I last saw him alive on March 4, 1924, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Spasmo

(duration ..... yrs. ..... mos. ..... ds.)

CONTRIBUTORY (Secondary) Indigestion (duration ..... yrs. ..... mos. ..... ds.)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. A. Zimmerman, M. D.

3/4, 1924 Address 2258 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer DATE OF BURIAL: March 6-24 19

20 UNDERTAKER: Jos J Otten & Son ADDRESS: 156 N Luzerne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84540

CERTIFICATE OF DEATH.

129 D 84540

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W. Hughes ST. 22 WARD)

2-FULL NAME Frank Stewart

(a) RESIDENCE NO. 17 W Hughes ST. 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Hettie Stewart

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 55; Months; Days; If LESS than 1 day ....hrs. or ....min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Tube works

(c) Name of employer: Ballo Tube Co'

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hattie Lee

(Address): W. F. Hall

15 Filed MAR 5 - 1924, 19 ....

Robert F. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/3/ 1924

17

I HEREBY CERTIFY, That I attended deceased from 2/24 1924 to 3/3/ 1924 that I last saw h.... alive on 3/3/ 1924, and that death occurred, on the date stated above, at 3.00 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis duration yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo Bowley, M. D.

19 (Address) 908 Ashland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 3-6 1924

20 UNDERTAKER: Daniel Forbes — ADDRESS 916 Pac Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84541

CERTIFICATE OF DEATH

D 84541

1-PLACE OF DEATH

City of BALTIMORE: (No. 2604 Maryland Ave Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Tice

(a) Residence No. 2604 Maryland Ave St..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S. (if of foreign birth)? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry Fuller Tice

6-DATE OF BIRTH (month, day and year) Sept 12, 1850

7-AGE. 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Talbott Co Md

PARENTS.

10-NAME OF FATHER, Valiant-

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Clendenin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Gertrude V. Tice

(Address) 2604 Maryland Ave

15- Filed MAR 5 - 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 5 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19.09 to Mar 4 ..... 19.24

that I last saw h.. alive on Mar 4 ..... 19.24

and that death occurred on the date stated above, at 4 A ..... m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis; hemiplegia.

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary?) Senile pneumonia

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mamie Lazenby M. D

Mar 5, 1924 (Address) 184 W Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md — DATE OF BURIAL: Mch 7 ... 1924

20-UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21—M&T—1500 Blks.

D 84542

HEALTH DEPARTMENT—CITY OF BALTIMORE.

16T-901 ✓ D 84542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Ramsay ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant - Stein

(a) RESIDENCE No. 2107 Ramsay St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 3/3/24

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day 17 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Geo. Stein

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Hettwig Beggrow

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant George Stein (Address) 2107 Ramsay St.

15 Filed ..... 19 ..... Robert P. Harrison Registrar

MAR 5 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4 1924

17

I HEREBY CERTIFY, That I attended deceased from 3/3, 1924, to 3/4, 1924.

that I last saw h[illegible] alive on 3/3, 1924,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 Months)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James A. Cazenovia, M. D.

3/4, 1924 (Address) 1729 E. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19 1924

20 UNDERTAKER Commissioner Health, — ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STATE OF MARYLAND
CERTIFICATE OF DEATH

D 84543

Registration Dist. No. ..... 1924 (Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH Florence Crittenton Mission

County .....

Village or City City (No. 537 Hollins St St.

2 FULL NAME James Marsh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	Single

6 DATE OF BIRTH about Nov (Month) 20 (Day) 1923 (Year)

7 AGE about 3 yrs. 5 mos. 1/2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Foundling

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Robert P. Harrison, REGISTRAR

APR 5 - 1924

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 4 (Day) 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1923, to Mar 4, 1924, that I last saw him alive on March 3, 1924, and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH * was as follows:

Pachymeningitis

Duration yrs. 2 mos. 14 ds.

Contributory
Secondary

Duration yrs. mos. ds.

(Signed) John L. Baldwin, M. D.

Mar 5, 1924 (Address) 1014 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL | DATE OF BURIAL ....., 191...

20 UNDERTAKER ..... | ADDRESS .....

If these blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

1208

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84544

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 E. North ave St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James D McConkey

(a) Residence No. 427 E. North ave St. Ward.....
(Usual place of abode)

(if non-resident give city or town and State)

Length of residence in city or town where death occurred abt. 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Annie McConkey

6-DATE OF BIRTH (month, day and year) March 7. 1861

7-AGE. 62 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer). Clerk

(c) Name of employer. Pennsylvania Railway

9-BIRTHPLACE (city or town) (State or Country), Philadelphia Pa

PARENTS.

10-NAME OF FATHER. Stephen McConkey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penna

12-MAIDEN NAME OF MOTHER. Louise Whitford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant) Mrs Annie McConkey

(Address) 427 E North ave

15-

Filed MAR 5 1924 192 Robert P. Marshall Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 4 1924

17- I HEREBY CERTIFY, That I attended deceased from July 2 19 24 to March 4 19 24

that I last saw h[illegible] alive on March 3 19 24

and that death occurred, on the date stated above, at 1 00 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Carl M. D

3/5, 1924 (Address) 41 Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. March 7 1924

20-UNDERTAKER. Chas. G. Black — ADDRESS 1424 W. North ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spic—12-23-21—E.B.R.S.—400 Bks.

D 84545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84545

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 423 N. 23rd & St- St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna Iacovacci

(a) Residence No. 423 N 23rd St- St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: ~~Male~~ Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Feb 8~~ 1924

6-DATE OF BIRTH (month, day and year): Feb. 8 1924

7-AGE. ..... yrs. ..... mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer): ~~Child~~

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Iacovacci

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Erica Iacovacci

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14-

(Informant) John Iacovacci

(Address) 423 N 23rd St.

15-

Filed MAR 5 - 1924 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch 4 1924

17- I HEREBY CERTIFY, That I attended deceased from 3-1-, 19 24, to 3-4-, 19 24

that I last saw h... alive on ....., 19....,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) S. A. Swanger, M. D.

3-5-, 1924 (Address) 1604 Linden

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Lincoln Mch 6, 1924

DATE OF BURIAL.

20-UNDERTAKER. Wm Cook

ADDRESS 902 E. Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 84546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84546

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Oakdale Road St.; 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth S. Lloyd

(Residence in Baltimore: No. 209 Oakdale Road St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. July 28 (Month) 1854 (Day) , 1 (Year)

7-AGE. 69 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Sudlersville, Md

PARENTS.

10-NAME OF FATHER, Stephen Bradley

11-BIRTHPLACE OF FATHER (State or Country) Sudlersville Md

12-MAIDEN NAME OF MOTHER Eliz Bradley

13-BIRTHPLACE OF MOTHER (State or Country), Sudlersville, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Fowler

(Address) 209 Oakdale Road

15-

Filed MAR 5 1924 E. P. Harrison, Registrar.

Forest Glen P

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 4 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1923, to March 4 1924, that I saw her alive on March 4 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(Duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) Sepsis from bed sores

(Duration) yrs. 1 mos. ds.

(Signed) Geo. M. Settle M. D.

March 5, 1924 (Address) 2435 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sudlersville, Queen Anne's Co., Md. DATE OF BURIAL, Mar. 5, 1924

20-UNDERTAKER Wm Cook & Son ADDRESS E. Main St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84547

CERTIFICATE OF DEATH.

74 D 84547

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Bank ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Falkenham

(a) RESIDENCE NO. 2004 Bank ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles M. Falkenham

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Tim

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible] Md.

12 MAIDEN NAME OF MOTHER Mary Tim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Benjamin Falkenham

(Address) 2001 Bank St.

15 Filed MAR 5 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1924, to March 3rd, 1924.

that I last saw h[illegible] alive on March 2nd, 1924,

and that death occurred, on the date stated above, at 2.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse nephritis, Cystitis, Pyelitis, cerebral hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) [illegible] M. D.

3/5, 1924 (Address) 6628 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 6 1924
20 UNDERTAKER	ADDRESS
Wendell Hyde & Son	315 Main

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84548

CERTIFICATE OF DEATH.

187-D 84548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norvell W Daniel

(a) RESIDENCE No. 4914 Teiquan Gwans WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lois S Daniel

6 DATE OF BIRTH (month, day, and year) Sept 24 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Acid Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer F. S. Royster 086

9 BIRTHPLACE (city or town) Stovall
(State or country) North Carolina

PARENTS

10 NAME OF FATHER James Daniel

11 BIRTHPLACE OF FATHER (city or town) Stovall
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ella Wilson

13 BIRTHPLACE OF MOTHER (city or town) Stovall
(State or country) North Carolina

14 Informant Lois S Daniel
(Address) 4914 Teiquan Gwans

MAR 5 Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Vertebrae

Caused by accidentally caught in revolving Shaft

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.

March 6, 1924 (Address) (Coroner.) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 2 days

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stovall, North Carolina

DATE OF BURIAL Mar 6 1924

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84549

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 W Lombard ST., 20 WARD)

2-FULL NAME Margaret J. Woodall

(a) RESIDENCE NO. 1933 W Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Woodall

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER James Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant James W. Woodall.

(Address) 1933 W Lombard

Filed ..... 19 ..... Robert T. Harrison, Burial Permit Clerk

MAR 5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1924, to Mar 5, 1924, that I last saw h— alive on Mar 4, 1924 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Jos. F. Snyder, M. D.

3/5, 1924 (Address) 1729 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Mar 7 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

Klingsville 4 or E 29th 10

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84550

CERTIFICATE OF DEATH.

31 D 84550

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 Hudson St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V. Bosley

(a) Residence No. 400 Hudson St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, Married or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Stowell J.

6-DATE OF BIRTH (month, day and year) Oct 11 1869

7-AGE. 54 yrs. 4 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) State or Country). Balto

PARENTS.

10-NAME OF FATHER, Joseph Keller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Catherine Dorsey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-INFORMANT Stowell J. Bosley

(Address) 400 Hudson St

15-

Filed MAR 5 1924

Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4 1924

17-I HEREBY CERTIFY, That I attended deceased from Sept 7th 1923 to March 4th 1924 that I last saw him alive on March 4th 1924 and that death occurred, on the date stated above, at 1550 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Filgotty M. D.

3/6 19 (Address) 401 E 25th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Mar 6 1924

DATE OF BURIAL.

20-UNDERTAKER, Wm Cook

ADDRESS 501 E Fort Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84551

CERTIFICATE OF DEATH.

D 84551

185

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: No. ..... ST., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan J. althouse

(a) RESIDENCE No. 712 E. 20th ST., ... WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 25 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, ~~or divorced~~ (HUSBAND of or) WIFE of: Widow of George althouse

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 79 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown. 87

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown. Va.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

15 Filed MAR 5 1924, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): mar. 4, 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1923 to mar. 3, 1924, that I last saw her alive on mar 3, 1924, and that death occurred, on the date stated above, at 7.25 a m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

Fracture of right hip. (Old

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Psychosis with Cerebral Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Edmunds M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

DATE OF BURIAL: March 7 1924

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Light

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84552

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 E Chase ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Cuddy

(a) RESIDENCE NO. 405 E Chase St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 10th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laun.

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Works

(c) Name of employer Armour & Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Peter Cuddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Monahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John Cuddy 2719 Edmondson

15 MAR 5 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1920, to March 4, 1924

that I last saw h[illegible] alive on March 4, 1924

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. 11 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos. F. U. Stevens, M. D.

3/4, 1924 (Address) 2878 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL March 7 1924

20 UNDERTAKER Margaret D. Flynn

ADDRESS 1422 Light St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84553

CERTIFICATE OF DEATH.

X181-001 D 84553

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 N. Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warner M. Burch

(a) RESIDENCE No Walstonburg, N.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Burch

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Mail Carrier R.F.D. & Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER ------- Burch

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ida Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Ray West (Address) Walstonburg N.C.

MAR 6 - 1924

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ijquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation
Probably Accidental
(Found in bath room, had just taken a bath.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Oates, M. D.
(Coroner)

Mar 5/24 192 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Walstonburg N.C.

DATE OF BURIAL: March 6 1924

UNDERTAKER: Joseph Owens

ADDRESS: 2218 Ryan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84554

CERTIFICATE OF DEATH.

31 D 84554

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Woodyear St. ST. 15 WARD)

2-FULL NAME Mary F Lewis

(a) RESIDENCE NO. 1315 Woodyear St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr. J. Schaffer
(Address) 702 Fremont St.

15 MAR 6 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroners (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Tuberculosis

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Pleurisy

..... (duration) ..... yrs. 6 mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

March 5, 1924 (Address) 2 E Fayette Madison 9x

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 3-6 1924

20 UNDERTAKER David Garbutt

ADDRESS 916 Cathedral

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84555

D 84555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Whitecoat St. 16 WARD)

2-FULL NAME Alexander Hardy

(a) RESIDENCE. No. 813 Whitecoat St. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Hardy.

6 DATE OF BIRTH (month, day, and year) Dec 15 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md.

PARENTS

10 NAME OF FATHER Benj. Hardy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Nancy Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Lizzie Hardy

(Address) Brooklyn Md

15 [illegible] 6 - 1924 HELEN N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1924, to Mar 4, 1924

that I last saw him alive on Mar 4, 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular.

(Signed) F. C. Smith, M. D.

Mar 5-1924 (Address) 607 N. Fort Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-6 1924
20 UNDERTAKER	ADDRESS 916
David Carter	Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84556

CERTIFICATE OF DEATH.

57 D 84556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3033 Westwood Av ST. 15 WARD)

2-FULL NAME Elizabeth K. Lewis

(a) RESIDENCE NO. 3033 Westwood Av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. T. Lewis

6 DATE OF BIRTH (month, day, and year) January 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co Md (State or country)

PARENTS

10 NAME OF FATHER Isaac Leister

11 BIRTHPLACE OF FATHER (city or town) Carroll Co Md (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Miller

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co Md (State or country)

14 Informant Annie Murray

(Address) 3033 Westwood Av

15 MAR 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from July 22 1923 to March 5 1924

that I last saw h alive on March 4 1924

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Disabilities Medical

duration 1 yrs. 11 mos. 15 ds.

CONTRIBUTORY (Secondary) Disabilities Cause (Cerebral Hemorrhage) duration yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Hurst M. D.

3/5/24 19 (Address) 924 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 8 1924
20 UNDERTAKER	ADDRESS 1944
Harry W. Elden	W. North Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84557

CERTIFICATE OF DEATH.

5 7 D 84557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1908 N. North Ave ST. 15 WARD)

2-FULL NAME Selina Wolf

(a) RESIDENCE NO. 1908 N. North Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Leo Wolf

6 DATE OF BIRTH (month, day, and year): Mar 13-1857

7 AGE: Years 66 | Months 11 | Days 22 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westchester Pa

PARENTS

10 NAME OF FATHER: Isaac Feld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Crawford

(Address): 1908 W. North Ave

MAR 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Spring of 1921 to March 5th 1924.

that I last saw her alive on March 5th 1924

and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 29 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Duvall, M. D.

, 19 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cem

DATE OF BURIAL: Mar 8 1924

20 UNDERTAKER: Harry W. Ehlen

ADDRESS 1944 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84558

CERTIFICATE OF DEATH.

44 D 84558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 N. Caroline ST., 8 WARD)

2-FULL NAME Kate Heesh

(a) RESIDENCE NO. 1731 N. Caroline ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Harry G Heesh

6 DATE OF BIRTH (month, day, and year) Jan 22nd 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John N Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Clara Goodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harry G Heesh
(Address) 1731 N. Caroline st

MAR 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I attended deceased from February 15, 1924, to March 4, 1924, that I last saw h[illegible] alive on March 3, 1924, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
General carcinomatosis

(duration) 5+ yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W Bastye, M. D.

M 4. 1924 (Address) 501 Sheldon Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	March 7th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Ilkn.

D 84559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 84559

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 N. Carey St. ST., 16 WARD)

2-FULL NAME Frank Brown

(a) RESIDENCE No. 1129 N. Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Brown

6 DATE OF BIRTH (month, day, and year) about 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto City (Water Dept.)

9 BIRTHPLACE (city or town) (State or country) N. Jersey

PARENTS

10 NAME OF FATHER Frank Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Thos. Berry
(Address) 836 N. Carey St.

15 MAR 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

March 4 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3-6 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Uhler St

Spec.—1-10-21—M&T—1500 Blks.

D 84560

Toll Pd

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 84560

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., V WARD)

2-FULL NAME James Pritchett

(a) RESIDENCE No. 1425 E. Pratt St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 2-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Wingate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address) JOHNS HOPKINS HOSPITAL.

15 MAR 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1924. to Mar 4 1924.

that I last saw him alive on Mar 4 1924.

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar

(duration) ..... yrs. 1 mos. ..... da.

CONTRIBUTORY (Secondary) Empyema 2nd ?

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 3/1-24

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. A. Wesch, M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wingate Pt. Dorchester Co. DATE OF BURIAL Mar 6 1924

20 UNDERTAKER H. Sander & Sons ADDRESS 710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84561

CERTIFICATE OF DEATH.

129 D 84561

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 620 Bartlett ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rau

(a) RESIDENCE NO. 620 Bartlett ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Rau

6 DATE OF BIRTH (month, day, and year) July 20-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Nicholaus Stauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma McDonald (Address) 620 Bartlett ave

15 Filed MAR 5 - 1924 ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 14, 1924, to Mch 5, 1924, that I last saw her alive on Mch 5, 1924, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

3,6, 1924 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine

DATE OF BURIAL 3/8 1924

20 UNDERTAKER Pickler & Pickler

ADDRESS 739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Mim.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84562

CERTIFICATE OF DEATH.

114 D 84562

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Bruce St. ST., 15 WARD)

2-FULL NAME Wm. T. Thompson

(a) RESIDENCE NO. 1415 Bruce St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannie Thompson.

6 DATE OF BIRTH (month, day, and year) March 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48		?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Cemetery
(c) Name of employer (General) Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannie Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hannie Thompson (Address) 1415 Bruce St.

15 MAR 6 1924 ROBERT R. KRAUTER, Register Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

ac. Dilatation of heart
Induration of Lungs (ac. Pneumonia)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) ac. Gastro-enteritis
(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)
March 3, 1924 (Address) 2802 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 6 1924
20 UNDERTAKER Jesse Redden	ADDRESS 4361 N. Bond St

Spec.—1-10-21—M&T—1500 Bks.

Beeder

HEALTH DEPARTMENT—CITY OF BALTIMORE

1923

D 84563

D 84563

CERTIFICATE OF DEATH.

15 129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1361 N Carey St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Reeder

(a) RESIDENCE No. 1361 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Reeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary M Cooper

(Address) 1361 N Carey St

15 Filed MAR 8 - 1924, 19..

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to March 5, 1924, that I last saw h alive on March 3, 1924, and that death occurred, on the date stated above, at 11.10 A, m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Pulmonary Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Age - Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. H. Wright, M. D.

March 5, 1924 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL March 8 1924

20 UNDERTAKER Thomas O Wright

ADDRESS 1361 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 D 84564

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1314 N Mound St ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Wallace

(Residence in Baltimore: No. 1314 N Mound St ; St.; 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) ..... (Day), 1855 (Year)

7-AGE, 68 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Caroline Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Wallace Son

(Address) 1314 N Mound St

15-

Filed MAR 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 4 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. E. Hennessy (Coroner.) M. D.

March 6, 1924 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ht Peace — DATE OF BURIAL, Mar 7th 1924

20-UNDERTAKER Emmert & Wright — ADDRESS 364 W Lanvale

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84565

CERTIFICATE OF DEATH.

D 84565

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2839 Boarman Ave 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard G. Levy.

(a) Residence No. 2839 Boarman Ave Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widower

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret L Levy.

6-DATE OF BIRTH (month, day and year): March 2 1851

7-AGE: 73 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS

10-NAME OF FATHER: William D. Levy.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederick Co Md

12-MAIDEN NAME OF MOTHER: Jane Elliott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14-INFORMANT: James W. Levy.

(Address): 2839 Boarman Ave

15-

MAR 6 - 1924

ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 5 1924 to Mar 5 1924

that I last saw him alive on Mar 2 1924

and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(Duration) Unknown ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. S. Hamilton M D

Mar 6, 1924 (Address) 109 W. Lee St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Mch 7, 1924

20-UNDERTAKER: John D. Mitchell

ADDRESS: 1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84566

CERTIFICATE OF DEATH.

164

D 84566

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 215 S. Ann St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna Grusczynski

(a) Residence No. 215 S. Ann St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 26 1830

7-AGE,	If LESS than 1 day,
94 yrs. — mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Poland
(State or Country),

PARENTS.

10-NAME OF FATHER, Unkown

11-BIRTHPLACE OF FATHER (city or town)..... Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Poland
(State or Country),

14-

(Informant) Mrs. Peter Matcuk

(Address) 215 S. Ann Street

15-

Filed MAR 6 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 4/24

17- I HEREBY CERTIFY, That I attended deceased from March 1, 19 24, to March 4, 19 24,

that I last saw h.. alive on March 4, 19 24,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile degeneration.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colitis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Johnston M. D.

March 5, 19 24 (Address) 14 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Stanislaus	March 7, 1924

20-UNDERTAKER.	ADDRESS
John A. Weber	1803 Bank St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84567

CERTIFICATE OF DEATH.

162 D 84567

1-PLACE OF DEATH Hosp. for Women of Md. 17

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant daughter of W. Lenox Barnes & May Kinsey Barnes.

(a) RESIDENCE NO. 2929 Guilford Ave, ST., Balt. Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3. 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER W. Lenox Barnes

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER May Kinsey

13 BIRTHPLACE OF MOTHER (city or town) Howard County (State or country) Maryland

14 Informant Mrs. H. G. LaMotte
(Address) Baltimore, Md.

MAR 6 - 1924 ROBERT R. KRAUTER,
MAR 6 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1924, to March 5, 1924, that I last saw her alive on March 5, 1924, and that death occurred, on the date stated above, at 4.06 p. m.

The CAUSE OF DEATH* was as follows:

Hyaline membrane Disease of the new born.

First symptoms at 7 a.m. today.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John M. C. Boyland, M. D.

, 19 (Address) 401 N. Braddish Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	March 6 1924
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84568

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 766 McHenry- ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lehnert-

(a) RESIDENCE. No. 766-McHenry- ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of): Mrs Caroline Lehnert.

6 DATE OF BIRTH (month, day, and year): Jan. 30. 1860

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	64	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter.

(b) General nature of industry, business, or establishment in which employed (or employer): House

(c) Name of employer: none.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Lehnert.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Wm Lawrence

(Address): 2728 W. Balto.

15 MAR 6 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 4 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1. 1923. to Mar. 4. 1924.

that I last saw him alive on Mar. 3. 1924.

and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) Hobart A. Hare, M. D.

, 19 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

DATE OF BURIAL: March 7 1924

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2175 Pac

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84569

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 S. Fulton Ave 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Burton

(a) Residence No. 109 S. Fulton Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~ Married, ~~Widowed~~ Widowed, ~~or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Kate M. Burton

6-DATE OF BIRTH (month, day and year) Aug 29 1850

7-AGE. 73 yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer.....

9-BIRTHPLACE (City or town).....
(State or Country) Baltimore Co md

PARENTS

10-NAME OF FATHER, Elijah Burton

11-BIRTHPLACE OF FATHER (City or town).....
(State or Country) Baltimore Co md

12-MAIDEN NAME OF MOTHER, Martha J. Candles

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country) Baltimore Co md

14-
(Informant) Kate M. Burton
(Address) 109 S. Fulton Ave

15-
MAR 6 - 1924

ROBERT R. KRAUTER,
Burial Permit Clerk-Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1923 to Nov 4 1924

that I last saw h— alive on Nov 4 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary tubercle

(Duration) 1 yrs. 1 mos. 11 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James F. Fitzgerald M. D

3/5, 1924 (Address) 1729 E. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	March 7 1924
20-UNDERTAKER.	ADDRESS
Jos Joerdens Son	2173 Pen.

~~NOTE—PENALTY for making any false statement in this certificate is imprisonment for not more than one year or fine of not more than $500 or both.~~ ~~should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.~~

Cor.—1-12-23—M&T—100 Bks.

D 84570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84570

CERTIFICATE OF DEATH.

176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Morlock

(a) RESIDENCE NO. 1507 Rutland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara E. Morlock

6 DATE OF BIRTH (month, day, and year) — 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk (formerly)
(b) General nature of industry, business, or establishment in which employed (or employer): with Penn. R.R.)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Morlock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Emily Pittrapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Clara E. Morlock

(Address): 1507 Rutland Ave

MAR 6 - 1924

Filed ..... 192 .....

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage- Pistol wounds thru heart. (Suicide)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Shot himself in Clifton Park

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Haller, M. D. (Coroner.)

March 5/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Mch 6 192 4

20 UNDERTAKER: Robert Turner Sons

ADDRESS: 1142 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84571

CERTIFICATE OF DEATH.

1645 D 84571

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1422 Clarkson St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances A. Woon

(a) Residence No. 1422 Clarkson St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jos. W. Woon

6-DATE OF BIRTH (month, day and year) July 16 1851

7-AGE. 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). At home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS

10-NAME OF FATHER, Thomas Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Mrs. D. Woon

(Address) 1422 Clarkson

15-

MAR 6 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 20 1924 to Mar 4 1924

that I last saw h.. alive on Mar 4 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

1) Inflammation of Bladder

(Duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. S. Campbell M. D.

(Address) 1644 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill Cemetery	Mar 7 ... 1924
20-UNDERTAKER.	**ADDRESS**
J. C. Krauss & Son	1638 Hanover

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84572

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Frisby

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1875

7-AGE. 49 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER James Frisby

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Ellen Feldstein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Municipal Hospital Records

(Address)

15- MAR 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-3-24

17- I HEREBY CERTIFY, That I attended deceased from 2-28 1924, to 3-3 1924

that I last saw him alive on 3-2 1924

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Hypertension, Chronic Nephritis

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia; Bronchio-Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Claude A. Drane, M. D

3-3, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state, (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Earl Kay	5/6
21-UNDERTAKER. Samuel Wesley	ADDRESS 1828 Eastern

Filed

WHITE LINES ONLY SHOULD BE TYPEWRITTEN. ALL ITEMS must be completed EXACTLY. PHYSICIANS should state CAUSE OF DEATH clearly and fully supplied. AGE should be stated EXACTLY. NAMES should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84573

CERTIFICATE OF DEATH.

185 D 84573

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmond O'C. Moore

(Residence in Baltimore: No. 1435 Gorsuch Ave. St.; Lifetime. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH. October 13th., 1885
(Month) (Day) (Year)

7-AGE. 38 yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer.
(b) General nature of industry, business, or establishment in which employed (or employer): Md. Casulty Co.

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. William Moore

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER. Cecelia T. Connor

13-BIRTHPLACE OF MOTHER (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Moore

(Address) 1435 Gorsuch Avenue.

MAR 6 - 1924, 191.... ROBERT R. KRAUTER,
Filed
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 5th. 1924., 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Fract. Skull Caused by accidentally falling down Steps of Mercantile Trust

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)
March, 1924. (Address) 639 Equ

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery.

DATE OF BURIAL. March 7. 1924

20-UNDERTAKER Chas. J. Kraus & Son

ADDRESS 1101 N. Mayfield Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE TEARING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84574
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 84574
Registered No. C.....

City of BALTIMORE: (No. 1057 Robert St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Frederick Ellen Adams

(Residence in Baltimore: No. 1057 Robert St.; yrs. 41 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH. Aug 7 (Month) (Day) 86 (Year)

7-AGE. 37 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rag Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Junk 045

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Adams

(Address) 1057 Robert St

15-
MAR 6 - 1924
ROBERT R. KRAUTER,
Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mar 4 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Poor Compensation

(Duration) yrs. mos. ds.

(Signed) James W Kemler M. D.
(Coroner.)

Mar 4 1924 (Address) 7 W E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL. Mar 6, 1924

20-UNDERTAKER. Brown & Leland ADDRESS 114 at

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 84575

REGISTERED No.

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. ST., 4 WARD)

2-FULL NAME James Warren Barnes

(a) RESIDENCE NO. 17 Dobson Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Baines

6 DATE OF BIRTH (month, day, and year): Unknown 1882

7 AGE: Years 39; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer): 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Alexander Baines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Minnie Baines.

(Address)

15 Filed MAR 6 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/3/ 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924 to March 3, 1924

that I last saw him alive on March 3, 1924

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Vascular Syphilis, Aortic Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Comfort Jr., M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: 3/6 1924

20 UNDERTAKER: Samuel Kennedy

ADDRESS 1168 N Bradford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84576

CERTIFICATE OF DEATH.

161-001 ✓ D 84576

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 N. West ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth May Smith

(Residence in Baltimore: No. 1814 N. West St.; ...yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Nov. 4, 1924
(Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, 20 hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Emory L. Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Frances Zeman

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emory L. Smith

(Address) 1814 N. Washington

15- MAR 6 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 5, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 4 1924, to Nov 5 1924, that I saw h[illegible] alive on Nov 5 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth Ins. Mes.

(Duration) ...yrs. ...mos. 1 ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) Jacob Frosh M. D.

Nov 5, 1924 (Address) 1523 N. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park | DATE OF BURIAL, 3/6/..., 1924

20-UNDERTAKER E. J. Fanning & Son. 1938 | ADDRESS E. Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84577

CERTIFICATE OF DEATH.

185 D 84577

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 W. Lexington ST.: 18 WARD)

2-FULL NAME John C. Gardiner

(a) RESIDENCE. No. 813 W. Lexington ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of R. Gardiner

6 DATE OF BIRTH (month, day, and year) 3/4/1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Hub Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gardiner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant John Gardiner

(Address) 1202 Holbrook St

15 Filed MAR 6 - 1924 19 ROBERT P. KRAUSE, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 4 1924

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1924, to March 4. 1924

that I last saw h. alive on March 4, 1924.

and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Accidental injury to Rt. Side of throat & Lung. (Cut)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Michel M. D.

March 1924 Address) 2401 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	3/8 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Bella Hall

HEALTH DEPARTMENT—CITY OF BALTIMORE

84578

CERTIFICATE OF DEATH.

101-001

84578

1-PLACE OF DEATH

City of BALTIMORE: (No.) 627 ... St., 17 ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bella Hall

(a) Residence No. 627 ... St., ... Ward ...

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, Married or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Hall

6-DATE OF BIRTH (month, day and year) May 23, 1892

7-AGE. 31 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cook

(b) General nature of industry, business, or establishment in which employed (or employer). ?

(c) Name of employer. Mrs Groaves

9-BIRTHPLACE (city or town) (State or Country). Petersburg, Va

PARENTS

10-NAME OF FATHER. Louis C Harrison

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Prince George Co Va

12-MAIDEN NAME OF MOTHER. Maggie Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Suffolk Co Va

14-

(Informant) John Hall

(Address) 627 George St.

15-

MAR 6 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1924 to March 5 1924

that I last saw h[illegible] alive on March 5 1924

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Cavan M. D.

, 19 (Address) 723 George St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Petersburg, Va. — DATE OF BURIAL. March 7, 1924

20-UNDERTAKER. Mrs. Nate R. Williams — ADDRESS 322 W. Sebrees St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84579 CERTIFICATE OF DEATH. 100-001 ✓ D 84579

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ben Jones

(a) Residence No. 503 groom alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 43 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). 0-10

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Kentucky

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ?

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15- Filed MAR 6 - 1924 ROBERT R. KRAUTER, Secretary. Burial Permit Clerk. 1210

16-

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-3-24

17- I HEREBY CERTIFY, That I attended deceased from 2-24, 1924 to 3-3, 1924

that I last saw him alive on 3-3, 1924

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sp

(Signed) Claude S. Bruce M. D.

3-4, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. DATE OF BURIAL. ....., 19....

UNDERTAKER. Commissioner Health. ADDRESS MAR 6 - 1924

Per Wm. E. Woodall

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84580

CERTIFICATE OF DEATH.

37 D 84580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 19 WARD)

2-FULL NAME Anthony Dabestzy

(a) RESIDENCE No. 1513 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 2 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer B & O. R. Train

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Dabocks Adolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER do not know name

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mary Dabestzy

(Address) 1513 W Mulberry St

MAR 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25th, 1924, to March 5th, 1924, that I last saw him alive on March 5th, 1924, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory findings.

(Signed) L. F. White, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Stanislo. Cemetery 8 March, 1924

20 UNDERTAKER — ADDRESS

Charles B. Kuchaucka 677 S. Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Stromel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84581

CERTIFICATE OF DEATH.

129

D 84581

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 737 S. Curley St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Stromel

(a) Residence No. 737 S. Curley St., 1 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, Divorced, (Write the word)~~ Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Stromel

6-DATE OF BIRTH (month, day and year) Sept 3rd 1865

7-AGE, 58 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired U.S. army

(b) General nature of industry, business, or establishment in which employed (or employer)..... 08

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Stromel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mrs Anna Stromel

(Address) 737 S. Curley St.

15-

MAR 6 - 1924

ROBERT R. KNAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 19 23 to March 4 19 24

that I last saw him alive on March 4 19 24

and that death occurred, on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

3/5 1924 (Signed) Horace A. Tidlow M. D

(Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel DATE OF BURIAL. Mar 7 1924

20-UNDERTAKER. Peter Nicolaus ADDRESS 2060 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K 0 0 A K

Spec.—1-10-21—M&T—1500 Blks.

D 84582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D 84582

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Vincent ST., 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel B. Braxton

(a) RESIDENCE NO. 228½ N. Vincent ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (Child)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER James Braxton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mysterie Murry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant James Braxton
(Address) 228½ N. Vincent St.

15 Filed AR 6 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 5, 1924, that I last saw her alive on March 5, 1924, and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James M Hayes, M. D.

3/6 1924 (Address) 513 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 7th 1924
20 UNDERTAKER	ADDRESS
A. Jones	W. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 84583

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3229 Fleet St. ST., 26 WARD)

2-FULL NAME Mary J. Frank

(a) RESIDENCE NO. 3229 Fleet St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Frank.

6 DATE OF BIRTH (month, day, and year) June 6-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at home. 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER John Hurley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John H. Frank. (Address) 3229 Fleet St.

15 [illegible] 19

Robert P. Harrison, Registrar

Burial Permit clerk.

AR 6 -1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Mar 4, 1924, that I last saw her alive on Mar 4, 1924 and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilden, M. D.

3/5, 1924 (Address) 315 S. Highland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Land Cem. DATE OF BURIAL Mch. 7 1924

20 UNDERTAKER Lilly and Zeile ADDRESS 403 S. Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84584 ✓ X 32 D 84584

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucille ~~Do~~ Mester

(a) RESIDENCE No. Deals Island, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Reed Mester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie Abbey

13 BIRTHPLACE OF MOTHER (city or town) Md.

14 Informant Mrs. Lottie Mester
(Address) Deals Island, Md.

15 Filed 192 Robert P. Harris M.D. Registrar

MAR 6 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Coroner find that said deceased came to ~~h~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ft. Meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

March 6, 1924 (Address) 802 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., ntos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deals Island Md. DATE OF BURIAL: Mch 6 192 4

20 UNDERTAKER: H E Wigley ADDRESS: 534 W. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84585

CERTIFICATE OF DEATH.

21

D 84585

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 5 WARD)

2-FULL NAME Benjamin Hall.

(a) RESIDENCE No. 20 N. High St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maggie Smyth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record.
(Address)

15 Filed MAR 6 - 1924 Robert P. Harrison Registrar
Special Trial Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/24 19

17

I HEREBY CERTIFY, That I attended deceased from 2/18/24, 19.... to 3/3/24, 19....,

that I last saw h—ive on 3/3/24, 19....,

and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Arteriosclerosis.

Chr. Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health. ADDRESS MAR 6 - 1924

Per. Wm. E. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... PATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 84586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84586

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Balto Md

CITY OF BALTIMORE: (No. 4700 Garrison Ave ST., 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F Heuse

(a) RESIDENCE No. 4700 Garrison ST. Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna F Heuse

6 DATE OF BIRTH (month, day, and year) Oct 3 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5		1 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Deputy Sheriff of Balto City

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER A Bernard Heuse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Trazman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lilian Heuse (daughter)

(Address) 4700 Garrison Ave

15 MAR 6 - 1924 19.....

Robert F. Harrison, Registrar

Myrtle Ferstt Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov ?, 1923, to March 4th, 1923.

that I last saw him alive on March 3rd, 1924,

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular insufficiency with Cardiac decompensation

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam & clinical symptoms

(Signed) Samuel H Culver M. D.

19 (Address) 4710 Liberty Hghts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/7 1924

UNDERTAKER Harry W. Means & Son

ADDRESS 805 N. Calvert St

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84587

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 S. Eden ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer David Cohen

(a) RESIDENCE NO. 238 S. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 52 — Months: — — Days: — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Mendle Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Harry Cohen

(Address) 238 S. Eden St

MAR 6 Filed 1924. 19 Robert P. Harris Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1924 to Mar 6 1924, that I last saw h— alive on Mar 5 1924, and that death occurred, on the date stated above, at 9.55 a. m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. .... mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation & Nephritis

(duration) yrs. 6 mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Ries, M. D.

Mch 1924 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai Hebrew Rem	March 7 1924
20 UNDERTAKER	**ADDRESS**
L. Furman Bro	E. Balto

F.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84588

CERTIFICATE OF DEATH.

13 170

D 84588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 E. Baltimore ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice Lehmayer

(a) RESIDENCE No 2108 Callow Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Pauline Lehmayer

6 DATE OF BIRTH (month, day, and year) Nov. 29 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Phialdelphia
(State or country) Pa.

PARENTS

10 NAME OF FATHER Joseph Lehmayer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Abraham Fader
(Address) 234 Brooks Lane

15 Filed MAR 6 1924 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/ 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Pistol Shot
wound in chest
Sudden (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

(Signed) H. O. Riley, M. D.
(Coroner.)
March, 1924 (Address) 1029 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Har Sinai Cemetery

DATE OF BURIAL 3/7/ 1924.

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84589

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1617 Eutaw Place St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Ida Shiller Bond

(a) Residence No. 1617 Eutaw Place St.,..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Wm Tipton Bond

6-DATE OF BIRTH (month, day and year) June 28, 1860

7-AGE, 63 yrs. 8 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House wife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Baltimore Co. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Samuel Shiller

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Mary Howard

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland

14- (Informant)..Wm J. Bond

(Address)..1617 Eutaw Place

15- Filed..MAR 6 1924, 192.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) MAR 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1923, to March 6, 1924, that I last saw h.. alive on March 5, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Spastic Paraplegia

.....

.....

.....

Spec.—1-10-21—M&T—1500 Bks.

D 84590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49

D 84590

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatz Klamer

(a) RESIDENCE NO. Pittsburg Pa ST., ... WARD Pittsburg Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pasta Klamer

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ticket Agent

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAR 6 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17

I HEREBY CERTIFY, That I attended deceased from March 5 , 1924, to March 6 , 1924,

that I last saw him alive on March 6 , 1924,

and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Bladder

ARM

(duration) 2 yrs. 2 mos 0 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff. Pul. Oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Pittsburg Pa

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Station of Carcinoma

(Signed) Robert Wormley, M.D.

, 19 (Address) Johns Hopkin Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa — DATE OF BURIAL March 6 1924

20 UNDERTAKER Joseph Abrens — ADDRESS 221 Ruxy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84591 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84591

1926B

CERTIFICATE OF DEATH. X 100-00

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney B. Howes

(a) RESIDENCE NO Perkins, Randolph, W. Va. WARD Parkins W. Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Atta Howes.

6 DATE OF BIRTH (month, day, and year) 1876.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Blylander Howes

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Friend JOHNS HOPKINS HOSPITAL.
(Address)

Filed MAR 6 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1924, to March 6, 1924.

that I last saw him alive on March 6, 1924.

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia Post Operative. (Duodenal Ulcer) Pneumothorax, left

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Ac. Dilatation Stomach

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? J.H.H.

Did an operation precede death? Yes Date of Feb. 25/24

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) F. P. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkins W Va — DATE OF BURIAL March 7 1924

20 UNDERTAKER Josepher Ahrens — ADDRESS 421 Ruxy

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva M. Chenoweth

(a) RESIDENCE NO. Fullerton Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred [redacted] yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laurence Chenoweth

6 DATE OF BIRTH (month, day, and year) May. 14, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fullerton Md.

PARENTS

10 NAME OF FATHER William Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emiguda Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Laurence Chenoweth

(Address) Fullerton Md.

15 Filed MAR 6 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1924 to Mar. 5, 1924.

that I last saw h[illegible] alive on Mar. 5, 1924,

and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Acute Nephritis

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tonsilitis + pharyngitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fullerton, Md

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. W. Sybert, M. D.

, 19 (Address) St. Jos. Hosp-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL Mar 8 1924

20 UNDERTAKER Mr & Mrs. John H. Teufel & Son ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84593

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Alverta Deitz

(a) RESIDENCE No. Hartford Road, Carney, Maryland WARD Carney Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Deitz

6 DATE OF BIRTH (month, day, and year) March 21, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Hebbville, Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Koontz

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) United States

12 MAIDEN NAME OF MOTHER Emma J. Macken

13 BIRTHPLACE OF MOTHER (city or town) Hebbville
(State or country) Maryland

14 Informant John L. Deitz
(Address) Carney, Maryland

15 Filed MAR 6 - 1924, 19.. Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1924, to March 6th, 1924, that I last saw her alive on March 6th, 1924, and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of March 5/24

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) L. M. Pahrst, M. D.

3-6, 1924 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL March 8 1924

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84594

CERTIFICATE OF DEATH.

100-004

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1906 Lemmon St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E Gettier jr

(a) Residence No. 1906 Lemmon St., ... Ward .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) June 14/23

7-AGE, ... yrs. 8 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Thomas E Gettier

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Laura M Wheat

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Braddock Md

14- (Informant) Thomas E Gettier

(Address) 1906 Lemmon St.

15- Filed, ... 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 6/24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15 — 19 24 to Mar 6 — 19 24

that I last saw him alive on Mar 6 — 19 24

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(over)

(Duration) ..... yrs. 20 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical —

(Signed) A Hilla Hemming M. D.

3/6, 1924 (Address) 2000 Hollins St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Bonnie Grant Md — DATE OF BURIAL, Mar 8, 19 24

20-UNDERTAKER, William Beck Sons — ADDRESS E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84595

CERTIFICATE OF DEATH.

31 D 84595

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2525 East Biddle St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida M. Dennstaedt

(a) Residence No. 2525 East Biddle St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced (Write the word.) Married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry

6-DATE OF BIRTH (month, day and year) May 30 1896

7-AGE 27 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 37

(c) Name of employer.....

9-BIRTHPLACE (City or Town) (State or Country) Harford Co Md

PARENTS.

10-NAME OF FATHER Wm W. Hopkins

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Harford Co Md

12-MAIDEN NAME OF MOTHER Kate Boughter

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Harford Co Md

14-(Informant) Henry Dennstaedt

(Address) 2525 E. Biddle

15-Filed Robert P. Harrison Registrar.

APR 6 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-4-24

17- I HEREBY CERTIFY, That I attended deceased from 2-1 1924 to 3-4 1924

that I last saw h... alive on 3-4-24

and that death occurred, on the date stated above, at 2.35 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —unknown—

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) H. T. Fuller Runyeday M. D.

(Address) 500 W Patt St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oakland — DATE OF BURIAL 3/7th 19 24

20-UNDERTAKER Wm Cook — ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84596

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 D 84596

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin St. Hospital 16 ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Florence Reilly

(Residence in Baltimore: No. 1224 W Cross ...St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Jan (Month) 18 (Day) 1902 (Year)

7-AGE: 22 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer): Candy Factory

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: George Reilly

11-BIRTHPLACE OF FATHER, (State or Country): Balto City

12-MAIDEN NAME OF MOTHER: Mary Corrigan

13-BIRTHPLACE OF MOTHER, (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Reilly

(Address) 1224 W Cross St

15- MAR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 6 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

Accident Taken by Mistake

(Duration) ...yrs. ...mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) James W. Benton M. D. (Coroner.)

March 6 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death ...yrs. 1 mos. 1/2 ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? 1226 W Cross St

Former or usual residence 1226 W Cross St

19-PLACE OF BURIAL OR REMOVAL: St Peters — DATE OF BURIAL: Mar 8th 1924

20-UNDERTAKER: John J Reddick — ADDRESS: 1200 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84597

CERTIFICATE OF DEATH.

90 D 84597

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1525 N. Lexington ST. 9 WARD)

2-FULL NAME Florence Fitzgerald

(a) RESIDENCE NO. 1525 N Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Cau | 5 Single, Married, Widowed, or Divorced. (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Fitzgerald

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years 37 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper for Self 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Dowdy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frank Fitzgerald

(Address) 1525 N Lexington St

MAR 7 - 1924

ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to March 6 1924

that I last saw h[illegible] alive on March 6 1924

and that death occurred, on the date stated above, at 930 PM

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Carotid misadventure

(duration) 6 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Coleman M. D.

, 19 (Address) 2039 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL Mar 8 1924

20 UNDERTAKER S. E. Brown & Son — ADDRESS 108 N Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84598

CERTIFICATE OF DEATH.

90 D 84598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 Greenmount Av ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Pendleton

(a) RESIDENCE NO. 838 Greenmount ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77y.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Servant
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) Talbott Co.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Gould

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Jane Kane

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Geo. H. Harden
(Address) 838 Greenmount Ave

15 Filed MAR 7 - 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Cerebral Hemorrhage

2

Duration (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner.)

March, 192 4 (Address) 1302 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL March 7 1924

20 UNDERTAKER Mrs J. G. Locks

ADDRESS 1302 Jefferson

(1) Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84599

CERTIFICATE OF DEATH.

37 D 84599

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wiesner

(a) Residence No. 519 S. Collington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md

PARENTS

10-NAME OF FATHER. John Wiesner

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore, Md

12-MAIDEN NAME OF MOTHER. Barbara Wiesner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore, Md

11- (Informant) Municipal Hospital Records

(Address)

15- MAR 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3 - 5 - 24

17- I HEREBY CERTIFY, That I attended deceased from 2 - 25 - 1924 to 3 - 5 - 1924 that I last saw him alive on 3 - 5 - 1924 and that death occurred, on the date stated above, at 9 35a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Acute Miliary)

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Lab + Autopsy

(Signed) Claude B. Heard M. D

3-5-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem DATE OF BURIAL. March 8, 1924

20-UNDERTAKER. F. W. Ozazuski ADDRESS 1930 Eastern Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84600

CERTIFICATE OF DEATH.

38 D 84600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 N. Carey. ST., 15 WARD)

2-FULL NAME Ernest. S. Cheney.

(a) RESIDENCE NO. 1328 N. Carey ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-20-24

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Henry Cheney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Anna B. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Henry W. Cheney. (Address) 1328 N. Carey St.

15 MAR 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6, 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1924 to Mar. 4 1924.

that I last saw him alive on Mar. 4, 1924.

and that death occurred, on the date stated above, at 2:50 A m.

The CAUSE OF DEATH* was as follows:

~~Broncho pneumonia with tuberculosis~~

Status lymphaticus ?

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) ~~Malignant~~ syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) S. R. Parsons per J. Fuhrer, M. D.

5-6, 1924 (Address) 1702 Westwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Mar 8 1924

20 UNDERTAKER: Geo. J. Pugh.

ADDRESS: 1735 Hoffman Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Harbor

CITY OF BALTIMORE: (No. Foot Lakewood Ave. ST., 1 WARD)

2-FULL NAME Wm Buoud

(a) RESIDENCE NO. " " ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

182 D 84601

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	b	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

087

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

MAR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.
THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

(Signed) Fd. Dalton Black, M. D.
(Coroner)
March 1, 1924 (Address) 1936 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Inatitutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	MAR 6 — 1924
20 UNDERTAKER Commissioner Health.	ADDRESS

Per. Wm. E. WOODALL

If LESS than one day, state HOURS and MINUTES. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84602

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 550 University Pkwy WARD 17)

2-FULL NAME Marguerite Woodruff Marston

(a) RESIDENCE No. 550 University Pkwy ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or Divorced, ~~(write the word)~~: Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Wm Staples Marston

6 DATE OF BIRTH (month, day, and year) 3-8-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	4	~	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Niagara Ontario

PARENTS

10 NAME OF FATHER: Joseph Woodruff.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Niagara-Ontario

12 MAIDEN NAME OF MOTHER: Julia Claus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ontario Canada

14 Informant (Address): Woodruff Marston 550 University Pkwy

Filed MAR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. , 1922 , to 3-4 , 1924 ,
that I last saw her alive on 3-4 , 1924 ,
and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:
CHR. PARENCHYM. NEPHRITIS

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Dorsey, M.D.
, 19 (Address) 1129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dorsey Ridge

DATE OF BURIAL: 3-7 1924

20 UNDERTAKER: Henry A. Jenkins Sons Co

ADDRESS: McCulloh Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002

D 84603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

2-FULL NAME Mary A. Bew,

(a) RESIDENCE NO. 21 S. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otis F. Bew.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 30; Months —; Days —; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —.

(c) Name of employer —.

9 BIRTHPLACE (city or town) (State or country): Va. King & Queen Co. Va

PARENTS

10 NAME OF FATHER Wm. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): King & Queen Co. Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hospital Records

(Address)

15 MAR 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 6, 1924, that I last saw h alive on March 6, 1924; and that death occurred, on the date stated above, at 1:20 a. m.

The CAUSE OF DEATH* was as follows:

Ludwig's Angina

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Abscess Tooth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of March 5, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Balto. Md.

DATE OF BURIAL: Mar 7 1924

20 UNDERTAKER: Wendell Hopkins

ADDRESS: 32 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 84604

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Orange Court St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Ricks

(Residence in Baltimore: No. 412 Orange Court St.; (yrs., 5) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Sept (Month) 19 (Day) 1907 (Year)

7-AGE: 17 yrs. mos. ds. If LESS than 1 day, hrs., or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 670

9-BIRTHPLACE, (State or Country): Richmond Va

PARENTS.

10-NAME OF FATHER: George Tucker

11-BIRTHPLACE OF FATHER, (State or Country): Richmond Va

12-MAIDEN NAME OF MOTHER: Phillis Yancy

13-BIRTHPLACE OF MOTHER, (State or Country): Richmond Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Ricks

(Address) 412 Orange Court

15- ROBERT R. KRAUTER, Filed MAR 7 - 1924 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: March (Month) 5 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held nn (~~Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said (~~Inquest, autopsy or~~ Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Tom Heating D Tuck Tobacco Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) W K Farnell M. D. (Coroner.)

3-6 1924 (Address) 117 W Saratoga St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery DATE OF BURIAL: 3/7/24 19

20-UNDERTAKER: Wm Gerthofer ADDRESS 406 W Lanvale st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Gregory

D 84605

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 84605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1111 Division St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Emily Gregoire

(a) Residence No. 1111 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married~~ Widowed, ~~or Divorced.~~ (Write the word.) widow

5a-If ~~married,~~ widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Lee Gregoire.

6-DATE OF BIRTH (month, day and year) 22 Jan. 1845

7-AGE. 79 yrs. 1 mos. 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, David Mack

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Tuft Russel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-

(Informant) Sister Florence

(Address) Preston Talbot Co.

15-Filed MAR 7 - 1924 ROBERT R. KRAUTER, Asst. Registrar,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 5/24

17- I HEREBY CERTIFY, That I attended deceased from No record 19... to ... 19...

that I last saw h. alive on March 3 19 24

and that death occurred, on the date stated above, at 7.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ... yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Warner, M. D

Me 4/24 19 (Address) 1133 Valley St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL, Mar 7 19 24

20-UNDERTAKER, H. C. Wiedefeld — ADDRESS 914 Greenmount Av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 84606

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Parker

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1869

7-AGE.	If LESS than 1 day,
55 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer .....

9-BIRTHPLACE (city or town). (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town). (State or Country). ?

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). ?

14- (Informant) Municipal Hospital Records

(Address) .....

15- FILED MAR 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-5-24

17- I HEREBY CERTIFY, That I attended deceased from 3-3- ..... 1924 to 3-5- 1924

that I last saw him alive on 3-5- 1924

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) Claude D. Grace M. D

3-5, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Chester Pa - Amer Ry Express	Mar 7, 1924
20-UNDERTAKER.	ADDRESS
John F Denny	715 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—(Q4-[illegible])—4500 Bks.

D 84607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 84607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hosp. (ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Fine

(a) RESIDENCE NO. 136 S. Exeter ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Fine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Fine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis (Address) 1439 E Balt St

Filed MAR 7 - 1924, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to March 7, 1924

that I last saw him alive on March 7, 1924

and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor J. Jury, M. D.

Mar. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 3/7 1924

20 UNDERTAKER Jack Levis 1439 E Balt St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 ✓ D 84608

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal 23 Hosp St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George Lewis

(a) Residence No. Aisquith St (225 N. Wolfe St.) St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 34 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer). 086

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Henry Lewis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Emma Hamilton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

11 (Informant). Patient

(Address).

15- MAR 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 19 23 to Mar 5 19 24

that I last saw h.. alive on Mar 5 1924 19.....

and that death occurred, on the date stated above, at 12 40 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. 2 weeks mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray - Sputum

(Signed) L. G. Lally M. D

, 19 (Address) Municipal 23 Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Asbury	March 8, 1924
20-UNDERTAKER. John W Henderson	ADDRESS 1602 E Monument

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Era. Morgan)

D 84609

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84609

CERTIFICATE OF DEATH.

#117

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St Joseph Hosp ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Era Morgan

(a) RESIDENCE NO. 311 Scarff St. ST., WARD St. Marys Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER John Harden

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Md

12 MAIDEN NAME OF MOTHER Susan Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Peter Morgan

(Address) 311 Scarff St

15 MAR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1924 to March 6 1924

that I last saw her alive on March 6 1924

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Senectus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 1, 1924

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) John C. Schenuit M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Co Md

DATE OF BURIAL: March 9 1924

20 UNDERTAKER: George J Smith

ADDRESS 1531 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 84610

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank ~~Brashears~~ Brashears

(a) RESIDENCE No. Lombard Everett ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ late Mary J. Brashears

6 DATE OF BIRTH (month, day, and year) Jan. 27 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Brashears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Kn

14 Informant Wm. James Ehrhart. (Address) 508 N. Collington Ave

15 MAR 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/ 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25 , 1924 , to March 6 , 1924 , that I last saw h/m alive on March 6 , 1924 , and that death occurred, on the date stated above, at 12:30 noon m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma - Palate.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & Findings

(Signed) Wm. J. Sutton, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Cnuses, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL March 10 1924

20 UNDERTAKER Henry Hoeck Son ADDRESS 801 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS PAPER CONTAINS NO CARBON. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84611

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-801

CERTIFICATE OF DEATH.

D 84611

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hopkins

(a) RESIDENCE No. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE: Years 60 | Months | Days | If LESS than 1 day, ... hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

11 Informant Municipal Hospital Records

(Address)

13 MAR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-11, 1922, to 3-4, 1924 that I last saw her alive on 3-4, 1924, and that death occurred, on the date stated above, at 8:00 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Ext.

(Signed) Claude T. Dixon, M. D.

3-5 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Hall Mt. Calvary — DATE OF BURIAL 3/6 1924

20 UNDERTAKER: Joseph K. Peddrew — ADDRESS 1436 N. Biddle St.

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 84612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54-002 D 84612

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 N. Bruce St. ST., 15 WARD)

2-FULL NAME Baby Shipley

(a) RESIDENCE NO. 1711 N. Bruce St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. A. Shipley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Gertrude Jones

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Wm. A. Shipley
(Address) 1711 N. Bruce St.

15 Filed MAR 7 - 1924 BY ROBERT F. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... inquest, au-
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Cardiac Paramus

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner)
March 7, 1924 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL FW Mon

DATE OF BURIAL March 7 1924

20 UNDERTAKER Sam. W. Chas Wax ADDRESS 1408 Hooker

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84613

90 ✓

D 84613

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 E. 28th St., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Anna Gunther

(a) RESIDENCE NO. 327 E 28th (Usual place of abode) ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Charles Gunther

6 DATE OF BIRTH (month, day, and year) June 9, 1843

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baetimore, Md.

PARENTS

10 NAME OF FATHER Dietrich H. Rodecke

11 BIRTHPLACE OF FATHER (city or town) Bremen (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Wedeman

13 BIRTHPLACE OF MOTHER (city or town) Bremen (State or country) Germany

14 Informant Daughter Bertha Gunther

(Address) 327 E. 28th St.

15 MAR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from October, 1923, to March 5, 1924,

that I last saw her alive on March 5, 1924,

and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) Geo McGean M. D.

3/5, 1924 (Address) 1203 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 3-8 1924

20 UNDERTAKER Mrs Chas G Rohde

ADDRESS 1200 N Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-80

D 84614

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 6 WARD)

2-FULL NAME Thomas Seddon

(a) RESIDENCE No. 422 N. Rose ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Maggie Seddon

6 DATE OF BIRTH (month, day, and year) Sept 25-1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Business self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Seddon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sallie Jarboe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant St Joseph Hospital
(Address) Richmond.

15 Filed MAR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 29, 1924 to March 6, 1924, that I last saw him alive on March 6, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Empyema following pneumonia.

(duration) yrs. mos 32 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff. (duration) yrs. mos. 1 Dy

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/1/24

Was there an autopsy? No.

What test confirmed diagnosis? Post-Operation

(Signed) Harold G. Gilchrist, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: March 9 1924

20 UNDERTAKER: Wm C. Miller — ADDRESS: 2334 Jeffer... St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 1-001 ✓ D 84615

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Burgundy ST., 17 WARD)

2-FULL NAME Mary Johnson

(a) RESIDENCE NO. 53 Burgundy ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 19-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ///

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti md

PARENTS

10 NAME OF FATHER Wilbert Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Daisy Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daisy Johnson
(Address)

15 Filed MAR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to March 5, 1924, that I last saw her alive on March 4, 1924, and that death occurred, on the date stated above, at 2.55 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

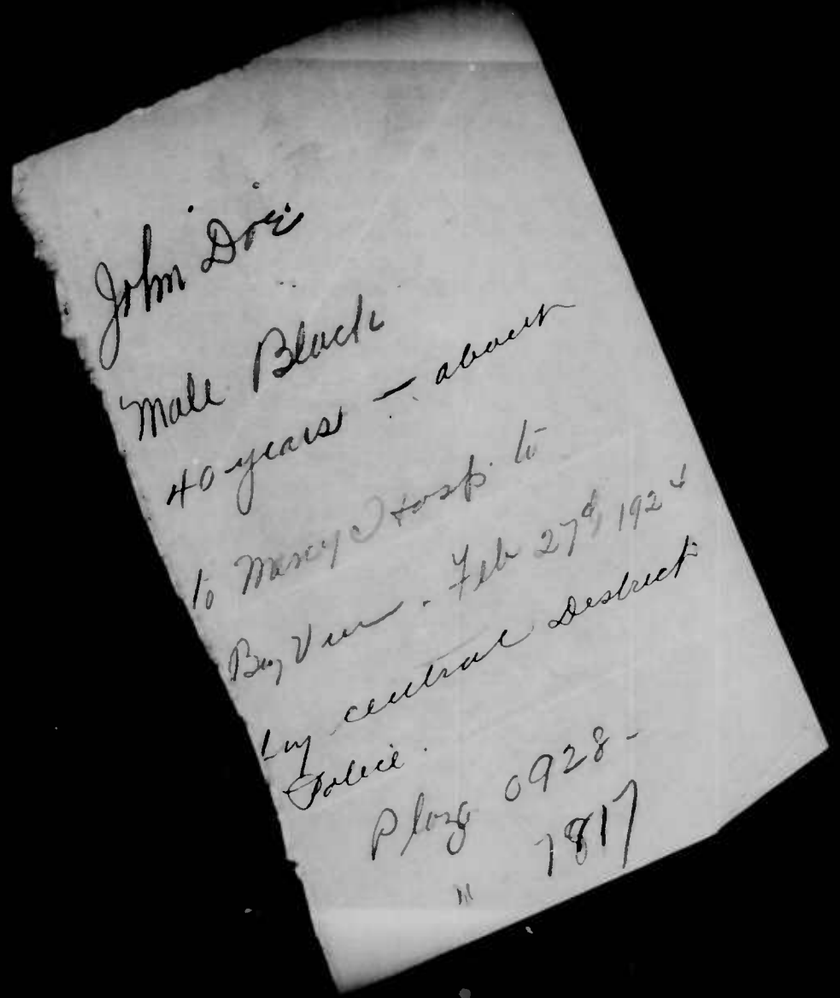
(Signed) Allons Reese, M. D.

2/6, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	March 7 1924
20 UNDERTAKER	**ADDRESS**
J. W. Bloom & Son	1088 W. Monty

U.S.A. KODAK SAFETY FILM



Spec—12-23-21—E.B.R.S.—400 Blks.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84616

CERTIFICATE OF DEATH.

D 84616

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James Anderson (John Doe)

(a) Residence No. ? St., ? Ward ?

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) ?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 50 above yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of Industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9-BIRTHPLACE (city or town) ? (State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND,

15- (Filed) MAR 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-5-24

17- I HEREBY CERTIFY, That I attended deceased from 2-29-24 19.. to 3-5 19 24

that I last saw h.. alive on 3-4 19 24

and that death occurred, on the date stated above, at 2^p a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Cerebral Hemorrhage

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude C. Grace M. D

3-5, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL, ... 19....

20-UNDERTAKER, Commissioner Health.

ADDRESS MAR 7 - 1924

Disinterred and buried at Asbury Cemetery May 15 1924 Edw. Bryan 634 Aiken St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

84617

Sarah Thomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 84617

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 833 N Decker ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Thomas

(a) RESIDENCE. No. 833 N Decker ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Thomas

6 DATE OF BIRTH (month, day, and year) August 10. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.	6	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover County Virginia

PARENTS

10 NAME OF FATHER James Lockwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover County Va

12 MAIDEN NAME OF MOTHER Emily Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Briggs (Address) 833 N Decker ave

15 MAR 7 - 1924 ROBERT R. KRAUTER, REGISTRAR Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1924, to March 5th, 1924, that I last saw her alive on March 5, 1924, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Ulceration of Stomach

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod. M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar. 8. 1924
20 UNDERTAKER	ADDRESS
Kendall & Heppe & Son	37 S Lime St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 84618

CERTIFICATE OF DEATH.

D 84618

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Williams

(a) Residence No. 110 Watson Steet St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. Yrs. Forty mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Jary Williams.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, Hannah Williams.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant).....

(Address).....

15- MAR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

1214

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/5/24.

17- I HEREBY CERTIFY, That I attended deceased from January 24 1924 to March 5, 1924, that I last saw him alive on March 5 1924 and that death occurred, on the date stated above, at 4-45 A. m.

The CAUSE OF DEATH* was as follows:

Frost bite gangrene feet - Septicemia.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 28, 24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Sulton M. D

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL, ..., 19....

20-UNDERTAKER.

ADDRESS

Commissioner Health.

MAR 7 1924

UNIVERSITY OF MARYLAND

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84619

OB 84619

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

Park Grs. & Monument or 74

City of BALTIMORE: (No. Winona Apts St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clintonia Warner Stork

(a) Residence No. Winona Apts St., 11 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 1 mos. 21 ds How long in U. S., if of foreign birth? 78 yrs. 1 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. L. Stork.

6-DATE OF BIRTH (month, day and year) Jany-12-1846

7-AGE, 78 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John Henry Warner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Mary Stack

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Maryland

14- (Informant) Mrs. B. F. Coles - (daughter)

(Address) Long Island - N. Y.

15- Robert P. Harrison

Filed ....., 192.....

Registrar.

R7 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 4th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1st, 1924., to March 4th, 1924., that I last saw h[illegible]ative on. March 4th, 1924., and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .....yrs. .....mos. 1/2 day.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Edgar D. Pothier, M. D.

March 4th, 1924 (Address) 1 W Franklin St (Residence)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cemetery — DATE OF BURIAL, March 8, 1924

20-UNDERTAKER, HERBERT & MOWEN COMPANY (WILLIAM F. MOWEN, Surviving) — ADDRESS 108 W. NORTH AVE

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS In plain terms, so that it may be properly classified. Exact statement of OCC instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D 84620

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327-E-25th ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rebecca Maxwell

(a) RESIDENCE NO. 327-E-25th ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? 60 yrs. 4 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) October-9-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Maxwell

11 BIRTHPLACE OF FATHER (city or town) London (State or country) England

12 MAIDEN NAME OF MOTHER B. Ann Quinlan

13 BIRTHPLACE OF MOTHER (city or town) Limerick (State or country) Ireland

14 Informant Miss Emilie R. Maxwell (Sister)

(Address) 327-E-25-St.-

15 MAR 7 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1924

17 I HEREBY CERTIFY, That I attended deceased from September, 1923, to March 5, 1924.

that I last saw her alive on March 4, 1924

and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) about 6 mos ds.

CONTRIBUTORY (Secondary) X (duration) X yrs. X mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of about 5 mo ago

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry Ch. Bayley M. D.

March 5 1924 (Address) 2805 E. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral (Loudon) DATE OF BURIAL May 8 1924

20 UNDERTAKER [illegible]RT & MOWEN COMPANY ([illegible]LIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84621

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 84621

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jones

(a) Residence No. 1309 N. Fremont St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Silas Jones

6-DATE OF BIRTH (month, day and year) 1874

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS

10-NAME OF FATHER, George Conoby

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Jane ? Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-(informant) Municipal Hospital Records

(Address)

15-Filed MAR 7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-6-24

17- I HEREBY CERTIFY, That I attended deceased from 1-12 1924 to 3-6 1924

that I last saw her alive on 3-6 1924

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Detioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude O. Grace M. D

3-7 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Mar 8 1924
20-UNDERTAKER.	ADDRESS
Moore & Elliott	745 Lanvale

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-801 ✓ D 84622

D 84622

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Keyser ST., 8 WARD)

2-FULL NAME Edward Warfield

(a) RESIDENCE No. 2044 Keyser ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Warfield

6 DATE OF BIRTH (month, day, and year) April 10/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	10	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Je an Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amanda Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jennie Warfield
(Address) 2044 Keyser St

15 Filed MAR 7 - 1924 '24 Robert P. Harrison Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inqury.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Apoplexy

(duration) one yrs. hour mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Collins (Coroner), M. D.

Mar 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 8 1924
20 UNDERTAKER Mac R. C. Elliott	ADDRESS 122 Oakland Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every question on this certificate should be answered. If information should be stated EXACTLY. PHYSICIAN should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84623 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84623

CERTIFICATE OF DEATH. 8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lyddledam Hospital ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ward.

(a) RESIDENCE NO. 2331 E. Chase ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mall	colrd	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md

PARENTS

10 NAME OF FATHER Casper Ward.

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) md

12 MAIDEN NAME OF MOTHER Catherine Lindendoerfer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14 Informant Catherine Ward (Address) 2331 E Chase

15 Filed MAR 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1924

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1924 to March 7, 1924

that I last saw living on March 7, 1924

and that death occurred, on the date stated above, at 10:50 a m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

Diphtheria, pharyngeal

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3/6/24

Was there an autopsy? No

What test confirmed diagnosis? culture (+)

(Signed) B. Hagerman M. D.

19 (Address) Lyddledam Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltolem

DATE OF BURIAL 3/8 1924

20 UNDERTAKER Philip Hennig

ADDRESS 2014 Orleans

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84624

CERTIFICATE OF DEATH.

165 D 84624

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 2 WARD)

2-FULL NAME Joseph Kubicki or Green

(a) RESIDENCE No 704 S. Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City Park Board

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Eastern Police District (Address)

15 Filed APR 7 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Starvation due to stricture of oesophagus following Muriatic acid swallowed on Nov 30/23 with suicidal intent. (Duration) at 11 S. Register yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Walker, M. D. (Coroner.)

Mar 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: March 8 1924

20 UNDERTAKER: F. W. Ozazewski — ADDRESS: 1980 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6520 Fait Ave. St. Hudson Heights Ward 26)

Registered No. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund. Ziemba

(a) Residence No. 6520 Fait Ave. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 16 1924

7-AGE.	If LESS than 1 day,
....yrs....mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Paul . Ziemba

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, Helen . Drecek

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country),

14- (Informant) Mr Paul . Ziemba

(Address) 6520 Fait Ave.

15- Filed 3/7 1924 Robert P. Harrison Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 7/24

17- I HEREBY CERTIFY, That I attended deceased from Feby 16 1924 to Mar 7 1924, that I last saw h alive on Mar 6 1924, and that death occurred on the date stated above, at 430 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia,

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. M. Clemmens, M. D.

3/7, 1924 (Address) Brudak, Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St Stanislaus	March 9, 1924

20-UNDERTAKER.	ADDRESS
John M Weber	1803 Bank St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 7 1924

Spec.—1-10-21—M&T—1500 Blks.

D 84626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84626

CERTIFICATE OF DEATH

Howard A. Kelly Hospital

1-PLACE OF DEATH 1418 Eutaw Place, Baltimore

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1418 Eutaw Pl ST., 14 WARD)

2-FULL NAME Eureba L. Bevier

(a) RESIDENCE NO. 1418 Eutaw Pl ST., Balto. WARD Olean N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 33 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Ernest Walter Bevier

6 DATE OF BIRTH (month, day, and year) Aug 20, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Portville, N. Y.

PARENTS

10 NAME OF FATHER Mr Frank Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER Lucretia Berlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Clarion Co Penn.

14 Informant: Mrs. H. F. Ray (daughter)
(Address)

15 Filed, ..., 19 ... Robert P. Harrison, Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8 19 24

17

I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Mar 8, 1924, that I last saw h[er] alive on Mar 8, 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar - rt

F (duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Carcinoma Breast - left.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ??

Did an operation precede death? Yes Date of Febs, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grant E. Ward, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Olean New York — DATE OF BURIAL: Febry 8 1924

20 UNDERTAKER: Chas. E. Black — ADDRESS: 742 W Fayette St

N. B.—WHILE PLANNED, WITH UNDERSTANDING AND CARE, every question on this certificate should be stated EXACTLY. PHYSICIAN'S AGE should be carefully supplied. AGE at last birthday of deceased should be stated EXACTLY. PHYSICIAN'S diagnosis of CAUSE OF DEATH should be stated EXACTLY. Every statement should be plain and clear, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1305 Hull St., 24 Ward)

Registered No. 001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Williams

(a) Residence No. 1305 Hull St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Williams

6-DATE OF BIRTH (month, day and year): July 17, 1857

7-AGE: 66 yrs. 7 mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mariner

(b) General nature of industry, business, or establishment in which employed (or employer): Captain

(c) Name of employer: Merchants Miners Trans Co

9-BIRTHPLACE (city or town) (State or Country): New Kent Co Va.

PARENTS.

10-NAME OF FATHER: Charles Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Caroline Binns

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14- (Informant): Mr. Roy Williams

(Address): 1305 Hull St

15-

Filed: Robert P. Harrison, Registrar.

MAR 8 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 5. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1. 1924 to March 5 1924

that I last saw him alive on March 4. 1924

and that death occurred, on the date stated above, at 10.05a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. F. A. Stevens, M. D

3/5, 1924 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: March 8 1924

UNDERTAKER: Wm C. Black ADDRESS: 927 N. Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84628

CERTIFICATE OF DEATH.

D 84628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N Payson ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Pridham

(a) RESIDENCE NO. 407 N Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin W Pridham

6 DATE OF BIRTH (month, day, and year): Feb 21 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jas. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edw W Pridham

(Address): 407 N Payson

15 MAR 8 1924 Albert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1923 to Mar. 5, 1924.

that I last saw her alive on 11 11, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Auto-intoxication

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 11

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Chas. H. Carlsday, M. D.

3/7 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 3/8 1924

20 UNDERTAKER: George A Fuhrman

ADDRESS: Fulton & Fayette

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84629.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84629

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 211 Gittings Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Madsen

(a) Residence No. 211 Gittings ave St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, (Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 17 1847

7-AGE. 77 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of Industry business, or establishment in which employed (or employer). Florist

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Denmark

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Denmark

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Denmark

14- (Informant) Mrs Paul Plaetsch

(Address) 211 Gittings ave

15- MAR 1 0 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar-8-1924

17- I HEREBY CERTIFY, That I attended deceased from March 6, 1924 to March 8 1924, that I last saw h.m alive on March 8 1924, and that death occurred, on the date stated above, at 7-20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Left Hemiplegia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Arterio-Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Dixon Porter M. D.

3/9, 1924 (Address) 422 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Govans Presb Church — DATE OF BURIAL, Mar 10 1924

20-UNDERTAKER. Josiah Depkenhoff & Son — ADDRESS North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84630

CERTIFICATE OF DEATH.

D 84630

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 Mosher St ST., 14 WARD)

REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Nesbit Murdoch

(a) RESIDENCE NO. 215 Mosher St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word) Widow

5a ~~Unmarried~~, widowed, or ~~divorced~~
HUSBAND of
(or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	92			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Samuel Murdoch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Susan Turnbull

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Wm Murdoch

(Address) 1527 Dalton St

15 Filed MAR 8 1924 Robert P. Harrison, Registrar

[Burial Permit Clerk]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 12th, 1924, to Mar 6th 1924.

that I last saw him alive on March 6th, 1924.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Senility

Progressive feebleness of mind & body for many months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm F. Lucas M.D.

3/7/1924 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	March 8 1924
20 UNDERTAKER	ADDRESS
Henry J. Jenkins & Sons Co	Eden & McCulloh

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. Information should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH should be stated so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 84631

CERTIFICATE OF DEATH.

16 29 84631

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harwood Heights ST. 25 WARD)

2-FULL NAME Baby Upman

(a) RESIDENCE No. Harwood Heights ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1d yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 6 24

7 AGE Years Months Days If LESS than 1 day 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lawrence Upman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Clara Locker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Lawrence Upman (Address) .....

15 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to March 6, 1924, that I last saw him alive on March 6, 1924, and that death occurred, on the date stated above, at 10:30 pm m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) 12 hours. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Spitzer MD

3. 19 24 (Address) 182 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: March 6 1924

20 UNDERTAKER: James Dignan & Co. — ADDRESS: 1000 S Paca St

R8

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84632

CERTIFICATE OF DEATH.

D 84632

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 3626 Connecticut Ave (WARD)

2-FULL NAME Margaret Hubbard

(a) RESIDENCE NO. 3626 Connecticut Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John Hubbard

6 DATE OF BIRTH (month, day, and year): Apl 2 1855

7 AGE: Years 68 | Months 11 | Days 5 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Henretta Malley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Clarence Stevens

(Address): Woodberry Md

15 Filed MAR 8 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to March 7, 1924, that I last saw h.. alive on March 6, 1924, and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 4 yrs. + mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. B Nourse, M. D.

Mar. 7, 1924 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Mar 8 1924

20 UNDERTAKER: GREENWETH & SON

ADDRESS: 2417 CHESTNUT AVE

Burial Permit Clerk

8.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS' ATTENTION IS CALLED TO THE IMPORTANCE OF FILLING IN THIS CERTIFICATE PROMPTLY AND CORRECTLY. Omissions and errors greatly delay the issuance of burial permits. AGE should be carefully supplied. Accurate information should be stated EXACTLY. PHYSICIANS should bear in mind that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84633

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D 84633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Found floating off

CITY OF BALTIMORE: (No. American Sugar Refinery ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Majka.

(a) RESIDENCE No 1818 Fleet St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced, HUSBAND of (XXXXXX) Mary Majka.

6 DATE OF BIRTH (month, day, and year) February 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Antone Majka.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Barany.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Majka (brother)
(Address) 255 S. Regester St.

15 Filed MAR 8 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

Missing January, 5, 1924.

16 DATE OF DEATH (month, day, and year) Body found floating March 6, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
probably accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

March 7, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	3/8/24
20 UNDERTAKER	ADDRESS
Jos. Zalewski & Sons	1118 Eastern

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Dr Bladder

D 84634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 84634

1-PLACE OF DEATH Bay View

REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry M Hasson

(a) RESIDENCE No. 1814 Eighth ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 21, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steam Fitter
(b) General nature of industry, business, or establishment in which employed (or employer) 060
(c) Name of employer A Matthews

9 BIRTHPLACE (city or town) Cecil County
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm C Hasson

11 BIRTHPLACE OF FATHER (city or town) Cecil Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lucie Weir

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co
(State or country) Md

14 Informant George M Hasson
(Address) 1814 Eighth St

15 Filed MAR 8 1924 192 Robert F. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... , M. D.
(Coroner.)

March 8, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery Cecil Co. Md.

DATE OF BURIAL Mar 10 1924

20 UNDERTAKER W Cook

ADDRESS 302 E Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84635 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 5137 Reisterstown Road St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Clarence H. Moore

(a) Residence No. 5137 Reisterstown Road St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Moore

6-DATE OF BIRTH (month, day and year) Sept 3 1893

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or mln.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Clarence H Moore

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Mary Conn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Mrs Mary Moore
(Address) 5137 Reisterstown Rd

15- Filed ..... 19.. Robert P. Harris, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to March 7, 1924 that I last saw him alive on March 6, 1924 and that death occurred, on the date stated above, at 12-5 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Pleurisy

..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. W. Buckley, M. D.

, 19 (Address) 126 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, Mch 10 1924

20-UNDERTAKER, Wm Cook & Son — ADDRESS Edmondson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84636

CERTIFICATE OF DEATH.

8 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 1223 N. Broadway, 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. King

(a) Residence No. 1223 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Col. Robert G. King

6-DATE OF BIRTH (month, day and year): Feby 1853.

7-AGE: 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS

10-NAME OF FATHER: John Poindrie

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Sophia Meyerd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14-Informant: Mrs Robert Hurst

(Address) 1223 N. Broadway

15-

Filed MAR 8 - 1924 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 7. 1924

17. I HEREBY CERTIFY, That I attended deceased from: Feby 1 1924 to March 7. 1924

that I last saw her alive on March 6 1924

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uraemia

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. McE Hunter M. D

, 19 (Address) 1415 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount DATE OF BURIAL: March 10, 1924

20-UNDERTAKER: John O. Mitchell ADDRESS: 1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 2-23-21–E.B.R.S.–400 Bks.

D 84637

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 84637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2010 Ashland Ave St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stitka

(a) Residence No. 2010 Ashland Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Stitka

6-DATE OF BIRTH (month, day and year): 1849

7-AGE: 77 yrs. mos. ds.

If LESS than 1 day: hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Austria

PARENTS.

10-NAME OF FATHER: Michael Stitka

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Austria

12-MAIDEN NAME OF MOTHER: Barbara Kubasta

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Austria

14-(Informant): Frances Stitka

(Address): 2010 Ashland Ave

15-Filed: Robert P. Harrison, Registrar.

MAR 8 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 6/24

17-I HEREBY CERTIFY, That I attended deceased from Mar 1 19 24 to Mar 6 19 24

that I last saw h alive on Mar 6 19 24

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Bauer M. D

(Address) 8926 Belvedere

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cat Hill	Mar 8, 1924
20-UNDERTAKER,	ADDRESS
Paul Eaves & Son	1906 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-OD 84638

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hospital ST., 17 WARD)

2-FULL NAME Samuel Carter

(a) RESIDENCE No. 953 Fenwick Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Carter.

6 DATE OF BIRTH (month, day, and year) June 6 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pool Room attendant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Staunton, Va.

PARENTS

10 NAME OF FATHER Samuel Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Barnum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Mary Whalen
(Address) 514 W. Mulberry St.

15 Filed MAR 8 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) D. J. T. Hennessy, M. D. (Coroner)

March 4, 1924 (Address) 288 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Laburnum Cem.

DATE OF BURIAL 3 10 192 4

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 84639

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 813 Saratoga St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Rod

(a) Residence No. 813 Saratoga St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Fem	Col	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 1 1849

7-AGE. 24 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) housework

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Wm. Roe.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Lara Lewis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Sarah Roe

(Address) 813 Saratoga St

15- Filed APR 8 1924, 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 6 24

17- I HEREBY CERTIFY, That I attended deceased from Feby 25, 1924, to Mar 6, 1924

that I last saw h.. alive on Mar 6, 1924

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) —

(Duration) .....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) David E. Trapnell, M. D.

(Address) 1701 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 3-10-24
Mt Auburn Cem	
20-UNDERTAKER. David Carlin	ADDRESS 916 Pa ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84640

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE (No. 1732 Patapsco Street 23 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise E. Thompson

(a) Residence No. 1732 Patapsco Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 6 1922

7-AGE, 1 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, Albert Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER, Julian Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (Informant) Albert Thompson

(Address) 1732 Patapsco St

15- Filed MAR 8 1924 Albert F. Bartlett Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mch 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 2 1924 to Mar 7 1924

that I last saw h[illegible] alive on Mar 7, 19

and that death occurred, on the date stated above, at 11.15 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Primary Date

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

Mar 8, 1924 (Address) 1644 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL, March 10 1924

20-UNDERTAKER Wm Cook — ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84641

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-08 D 84641

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 2322 Etting St. ST., 14 WARD)

2-FULL NAME Dora Tate

(a) RESIDENCE No. 2322 Etting St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Tate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Alice Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Morris Callahan
(Address) 1603 Lorman St

15 Filed MAR 8 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner's Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

March 8, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 3/8 1924

20 UNDERTAKER Samuel Hensley ADDRESS 1818 W. Baltimore

Cor.—1-12-23—M&T—100 Bks.

D 84642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 14 WARD)

REGISTERED No. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Brown

(a) RESIDENCE No 1401 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): May 21/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Richmond Va.

PARENTS

10 NAME OF FATHER: not given

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Johns Hopkins Hospital
(Address)

15 Filed MAR 8 - 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Terminal)

(Autopsy at Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Gastro-intestinal indigestion (duration) yrs. mos. ds.

(Signed) J. S. H. Oatten, (Coroner.) M. D.

Mar 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Southern Cem

DATE OF BURIAL: March 7 1924

UNDERTAKER: Martin Parker & Son

ADDRESS: 827 W North Ave

Cor.—1-12-23—M&T—100 Bks.

(Testman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84643

CERTIFICATE OF DEATH.

56 D 84643

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S. Caroline ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernst. C. Testman

(a) RESIDENCE NO. 126 S Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Fleet

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Xanthia Testman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Peter C. Testman
(Address) 126 S. Caroline st

15 MAR 8 - 1924 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rupture

Hernia (duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Wm. H. Hamilton, M. D.
(Coroner.)
March 7, 1924 (Address) 4 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 8 1924
20 UNDERTAKER	ADDRESS
Wm. Edward A. Bailey	Fayette

Local Registration Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

17 of 23

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 B 84644

X 17 B 84644

REGISTERED No.

1. PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME William W. Baker

(a) RESIDENCE No. Evensburg, Pa ST., WARD Evensburg Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X Widower

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER William Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Margaret Woden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 MAR 8 - 1924 Robert P. Harrison, .19 ...
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924 to March 8, 1924.

that I last saw her alive on March 8, 1924,

and that death occurred, on the date stated above, at 7:35 a. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, bilateral.

(duration) ? yrs. ? mos. — ds.

CONTRIBUTORY (Secondary) Congenital hypertrophy, vesical trabeculae. Carcinoma of bladder, papilloma. Secondary anuria (duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Lancaster, Pa.

Did an operation precede death? Yes. Date of March 7, 1924

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnstown Pa	March 8, 1924
UNDERTAKER	ADDRESS
Joseph Ahrens	221 B Way

(a)—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84645

168

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2518 Hollins St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E Krantes

(Residence in Baltimore: No. 2518 Hollins St.; yrs. 28 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Sept (Month) 6 (Day) 1896 (Year)

7-AGE: 27 yrs. 5 mos. 29 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balt City

PARENTS.

10-NAME OF FATHER: Christian Krantes

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Minnie Faber

13-BIRTHPLACE OF MOTHER, (State or Country): Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Informant: Elizabeth Heisler

(Address) 2518 Hollins St

15- Filed MAR 8 - 1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 5 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging Suicide

(Duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Mentally Deficient

(Duration) 2½ yrs. mos. ds.

(Signed) James M. Kelly M. D. (Coroner.)

Mar 6 1924 (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL, March 8 1924

20-UNDERTAKER: George Schwab ADDRESS Northern Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1090 Bks.

D 84646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84646

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto. Md.

CITY OF BALTIMORE: (No. 3602 Forest Park Ave. ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ring Parsons

(a) RESIDENCE. No. 3602 Forest Park Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John N. Parsons.

6 DATE OF BIRTH (month, day, and year) December 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
-	73	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster. Ohio.

PARENTS

10 NAME OF FATHER Geo. Ring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Susanna Ludwig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Daughter - Susanna R. Parsons (Address) 3602 Forest Park Ave.

15 Filed MAR 8 - 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8th 1924.

17

I HEREBY CERTIFY, That I attended deceased from Mar. 2nd, 1924, to Mar. 8th, 1924, that I last saw her alive on Mar. 2nd, 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Infarction with Acute dilatation of Heart

Angina Pectoris

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mitral Stenosis with Cardiac Insufficiency

(duration) 15 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? In Nebraska.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Diagnosis

(Signed) Fred H. Clark, M. D.

, 19 (Address) 3327 Fourth Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lincoln Nebraska	Mar 11 192[illegible]

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84647

32

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 W. Lombard ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Nelson Dorsch

(a) RESIDENCE NO. 1338 W. Lombard ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer "

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John C. Dorsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline Stamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John C. Dorsch (Address) 1338 W. Lombard St

15 Filed MAR 8 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1924

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 7, 1924, that I last saw him alive on March 7, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis?

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward F. Garner, M. D.

Mar 7 1924 (Address) 2604 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 10 '24
20 UNDERTAKER	**ADDRESS**
Harry H. Witzke	1031 W. Lombard

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

See Letter in file April 9th 1924

D 84648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 D 84648

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel W. DeMena (also known as Ethel Ward Master)

(a) Residence No. 1103 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert DeMena

6-DATE OF BIRTH (month, day and year) June 27, 1890

7-AGE. 33 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER. Arthur Ward

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER, Mary Parrish

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) Robert DeMena

(Address) 1103 Barclay St.,

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

MAR 8 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 8/924

17- I HEREBY CERTIFY, That I attended deceased from Mar 6, 1924, to Mar 8, 1924

that I last saw h.. alive on Mar 8, 1924,

and that death occurred, on the date stated above, at 3.10 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis Ulcerat

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) D. W. Howard, M. D.

Mar 8, 1924 (Address) 124 W. Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Jersey City, N. J.	3/8 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 84649

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2346 Frederick Ave 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary A Lentz

(a) Residence No.. 2346 Frederick Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? 85 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William F Lentz

6-DATE OF BIRTH (month, day and year) Feb 27 1839

7-AGE, 85 yrs. 5 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... At Home 037
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George Gerhard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Maggie E Everard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) William F Lentz
(Address) 2346 Frederick Ave

15- MAR 9 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 8 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1924 to March 8, 1924, that I last saw her alive on March 7, 1924, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

(Duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ..... yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) H. Reed Dean, M. D.

, 19 (Address) 4207 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL.
Woodlawn Cemt March 10, 1924

20-UNDERTAKER. — ADDRESS
William Cadwe & Nathan

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84650

CERTIFICATE OF DEATH.

100-001 ✓ D 84650

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 21 WARD)

2-FULL NAME Margaret Sunderland

(a) RESIDENCE NO. 818 Columbia av ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 11th 1923

7 AGE Years ..... Months 4 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wade C Sunderland

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Fink

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Wade Sunderland
(Address) 818 Columbia av

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 1924, to 3/7, 1924, that I last saw h alive on 3/7, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Malnutrition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) John M. Edwards, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 10 1924
20 UNDERTAKER	ADDRESS
John J Falls	1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

D 84651

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 84651

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 934 Brooks Lane ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Shepard

(Residence in Baltimore: No. 934 Brooks Lane St.: 35 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Unknown (Month), 1 (Day) (Year)

7-AGE: 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housemaid
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Russia

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jack Lewis

(Address) 1439 E Balto St

15

ROBERT R. KRAUTER,
Burial Permit REGISTRAR

Filed ..... 191 .....

MAR 9 - 1924

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Mar. (Month) 8 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Mar 8 1924 that I saw h[illegible] alive on Mar 7 1924 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma B Pancreas & Liver

(Duration) ..... yrs. 9 mos. ..... ds

Contributory (SECONDARY) Exhaustion

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) I. Seligman M. D.

Mar 8, 1924 (Address) 1920 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Bath Hebrew Cem. DATE OF BURIAL: 3-9 1924

20-UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84652 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D 84652

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 541 Robert street St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ethel Poppenovitz or Livew R.a.m., m.d.

(a) Residence No. 541 Robert street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Solomon Poppenovitz

6-DATE OF BIRTH (month, day and year)

7-AGE, 64 R.a.m., m.d. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer do

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Jack Lewis

(Address) 1439 E Balto St

15- Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 7 1924

17- I HEREBY CERTIFY, That I attended deceased from July, 19 23 to March 7th 19 24

that I last saw her alive on March 7 19 24

and that death occurred, on the date stated above, at 6.45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, Arterio Sclerosis

Chronic Pyelitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) D.T. Mendelson M. D.

, 19 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Rikeiem Rosedale | DATE OF BURIAL. 3/9, 1924

20-UNDERTAKER. Jack Lewis 1439 | ADDRESS E Balto St

Burial Permit

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84653

D 84653 28

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 N Carrollton Ave ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M Lecato

(a) RESIDENCE No. 1111 N Carrollton Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas H Le Cato

6 DATE OF BIRTH (month, day, and year) Oct 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin G Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Rosa J Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Chas H Le Cato

(Address) 1111 N Carrollton Ave

15 Filed MAR 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1923 to May 7, 1924.

that I last saw h Ed alive on May 7, 1924

and that death occurred, on the date stated above, at 2:35 P m.

The CAUSE OF DEATH* was as follows:

General Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis about (duration) yrs. 7 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H. Fotpaine, M. D.

, 19 (Address) 1019 Dan Hillman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon DATE OF BURIAL May 10th 1924

20 UNDERTAKER Harmon Coldwell ADDRESS 1364 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 84654

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84654

CERTIFICATE OF DEATH.

113

Registered No C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 707 Edmondson Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Justine Gordon

(Residence in Baltimore: No. 707 Edmondson Ave St.; yrs., mos. ds.)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH: April 15, 1923 (Month) (Day) (Year)

7-AGE: 1 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER, John Gordon — City

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Lillie Thomas

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Gordon

(Address) 707 Edmondson Ave

15- MAR 3 - 1924

Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

Central.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.

March 5, 1924 (Address) 2 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, [illegible] — DATE OF BURIAL, March 6th 1924

20-UNDERTAKER Clarence Edwards — ADDRESS 1964 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84655

CERTIFICATE OF DEATH.

101-001 ✓

D 84655

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 East Cross ST., 10 WARD)

2-FULL NAME Peter Mc Namee

(a) RESIDENCE No. 1440 East Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Cox

6 DATE OF BIRTH (month, day, and year) 8-22-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Clyde Line

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johnstown Pa

PARENTS

10 NAME OF FATHER Michael McNamee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine A Hinkle

(Address) 1440 E Cross St

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-1924

17 I HEREBY CERTIFY, That I attended deceased from 3-3-, 1924, to 3-7-, 1924

that I last saw him alive on 3-7-, 1924,

and that death occurred, on the date stated above, at 2-P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) H E Buxton, M. D.

3/8, 1924 (Address) 201 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R C	3-10 1924
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E West St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84656

CERTIFICATE OF DEATH.

100-001 ✓ D 84656

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2429 Maryland Ave St., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha B. Stubenrauch.

(a) RESIDENCE NO. 2429 Maryland Ave St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Male~~ Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Geo. Stubenrauch.

6 DATE OF BIRTH (month, day, and year) April 10 1840

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
83	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER (unknown.) Leutz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Dr. Chas. Stubenrauch. (Address) Havana. Fla.

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1924

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1924, to March 7, 1924, that I last saw h.. alive on March 7, 1924, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Senile arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? 0 Date of

Was there an autopsy? 0

What test confirmed diagnosis? none

(Signed) J. T. Owens, M. D.

3/8 1924 (Address) 804 Caton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 3-10 1924

20 UNDERTAKER Mrs Chas. A. G. Schultz

ADDRESS 600 N Carlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84657

CERTIFICATE OF DEATH.

100-08

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Jones

(a) Residence No. 907 McDonough St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Jones

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Va.

PARENTS.

10-NAME OF FATHER. George Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Anna Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) John Briggs

(Address) 1623 Miller St

15- Filed 192

ROBERT R. KRAUTER, Registrar.

MAR 9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/6/24.

17- I HEREBY CERTIFY, That I attended deceased from Jan 26 1924 to March 6 1924

that I last saw h.im alive on March 6 1924

and that death occurred, on the date stated above, at 6-40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pernicious Abscess 2

Syphilis (Duration) yrs. mos. 42 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton, M. D

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery DATE OF BURIAL, Mar 9, 1924

20-UNDERTAKER, Mrs. R. G. Elliott ADDRESS 725 Cumberland

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 3001 ✓ D 84658

D 84658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Maryland ST. 17 WARD)

2-FULL NAME Jake Kennedy

(a) RESIDENCE (Usual place of abode) No. 1731 Maryland ST. WARD.

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Kennedy

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. OHO

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Jake Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Georgi Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Susanne Kennedy (Address) 1731 Maryland

15 Filed MAR 9 - 1924 19.. ROSETTA R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 6, 1924, that I last saw h[illegible] alive on March 6, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 24 (Address) 11 W 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lincoln Cem.	Mar 9 1924
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1724 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84659

CERTIFICATE OF DEATH.

19 D 84659

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 7 WARD)

2-FULL NAME Isaac Hodge

(a) RESIDENCE No 1031 N. Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 10/1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min
	30	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Drake's Branch, (State or country) Va.

PARENTS

10 NAME OF FATHER Isaac Hodge Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Isaac Hodge

(Address) Sparrows Point Md.

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound through chest
Homicide- Inquest to be held
Mar 10/24

.....(duration) .....yrs. .....mos .....ds.

CONTRIBUTORY (Secondary)

.....(duration) .....yrs. .....mos. .....ds.

(Signed) H. J. Weller, M. D.

(Coroner.)

Mar 9/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Drakes Branch Va	Mar 11 1924
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	Parkland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84660

CERTIFICATE OF DEATH.

D 84660

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 500 Woodlawn Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Emma Stuart

(a) Residence No.... 500 Woodlawn Rd St., 27 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ? mos. ? ds How long in U. S., if of foreign birth? 60 yrs. 3 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) Nov-26-1863

7-AGE, 60 yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Midway S.C.

PARENTS.

10-NAME OF FATHER, Benj. R. Stuart

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Charleston S.C.

12-MAIDEN NAME OF MOTHER, Emma Thompson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Midway S.C.

14-

(Informant) Albert Rhett Stuart

(Address) 500 Woodlawn Rd.

15-

MAR 9 - 1924 ROBERT F. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 8. 1924

17- Oct 7 1923 to Mar 8 1924

I HEREBY CERTIFY, That I attended deceased from

that I last saw h.e alive on Mar 7 1924, 19.....

and that death occurred, on the date stated above, at 8-10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) 6+ yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Tilson Lorle, M. D.

3/8, 1924 (Address) 422 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Washington D.C. DATE OF BURIAL, Mar 10 1924

20-UNDERTAKER, GEO. E. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS, 103 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCC instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84661

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2563 McCulloughSt. 12 WARD)

2-FULL NAME Luna Rebecca O'Donnell

(a) RESIDENCE No. 2563 McCullough St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 24 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): Shirt Factory

(c) Name of employer: Wise Bros

9 BIRTHPLACE (city or town) (State or country): Rusford Co Md

PARENTS

10 NAME OF FATHER: George O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Emma Wayne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: Lida O'Donnell

(Address) 165 Ridgewood Rd Roland

15 MAR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 1920, to March 7, 1924, that I last saw her alive on March 7, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 hour ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Paul O Jewett, M. D.

March 8, 1924 (Address) 2516 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dignalius Hackey Md. DATE OF BURIAL: March 11/24

20 UNDERTAKER: Martin Fahey & Sons ADDRESS: 527 W North

Spec.—1-16-21—M&S—1500 Bks.

1 1800 84662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 84662

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Charles Casey

(a) RESIDENCE No. 701 N. Fremont Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maria Casey

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Levina Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 MAR 9 - 1924 ROBT. R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1924 to Mar 8, 1924.

that I last saw him alive on Mar 8, 1924,

and that death occurred, on the date stated above, at 2309 m.

The CAUSE OF DEATH* was as follows:

Melanotic sarcomatosis

metastases in every organ of body

(1 yr. following removal of mole from heel)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? Yes. Date of 1 yr. ago.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL MAR 10 1924 19

20 UNDERTAKER Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Barclay ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Christ

(a) RESIDENCE NO. 1705 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Christ

6 DATE OF BIRTH (month, day, and year) April 5 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margaret Davis

(Address) 1705 Barclay St

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to Mar 7, 1924.

that I last saw h[illegible] alive on Mar 6, 1924.

and that death occurred, on the date stated above, at 9.45 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

Indefinite. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) 1107 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	March 11 1924
20 UNDERTAKER	ADDRESS
Frank A. Tenk	915 N. Eagle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84664

CERTIFICATE OF DEATH.

D 84664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 West 27th St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry C. Loy.

(a) RESIDENCE. No. 111 West 27th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Renner Loy

6 DATE OF BIRTH (month, day, and year) Jan 20th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector Engines

(b) General nature of industry, business, or establishment in which employed (or employer) P. Rma R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Loys, Md.

PARENTS

10 NAME OF FATHER Martin Loy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loys, Md.

12 MAIDEN NAME OF MOTHER Mary A Hance

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alice Renner Loy (Address) 111 West 27th St

15 MAR 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to March 1, 1924, that I last saw h[illegible] alive on March 1, 1924, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Carcinoma of Bladder (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

[illegible] 19[illegible] (Address) 1112 W. 27th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Thurmont Md.	March 10 1924

20 UNDERTAKER Chas. G. Black ADDRESS 742 N. North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84665

CERTIFICATE OF DEATH.

101-001 ✓ D 84665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mary Hospital ST., 16 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Putsche

(a) RESIDENCE No. 170 y Edmondson Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX [illegible] 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word) Female white married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Putsche

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Joseph Hughes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Emma Swainwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records
(Address)

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Burial Permit (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/24

17 I HEREBY CERTIFY, That I attended deceased from 2/13/24, 19..., to 3/6/24, 19...
that I last saw h[illegible] alive on 3/6/24, 19...
and that death occurred, on the date stated above, at 12.30 P.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chr. Emphysema. Edema. (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Hall, M. D.

, 19 (Address) Mary Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	3/10 1924
20 UNDERTAKER George A. Farley Funeral	ADDRESS 1 Fayette

3.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 D 84666

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Freda Ave. ST., Lauraville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Branflick.

(a) RESIDENCE No. 206 Freda Ave. ST., Lauraville WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgianna E. Branflick

6 DATE OF BIRTH (month, day, and year) June [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Unknown

14 Informant Mary V. Branflick (Address) 206 Freda Ave Lauraville

15 Filed MAR 9 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1924, to March 8, 1924, that I last saw h— alive on March 7, 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Appearance of Pneumonia under Rales all over both lungs

(Signed) [illegible], M. D.

March 8 1924 (Address) St. Agnes Hospital 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL March 11 1924

20 UNDERTAKER Frederick Lasseter Sons — ADDRESS Fullerton Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84667

CERTIFICATE OF DEATH.

75-001 D 84667

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 N. Fremont Av. ST. 16 WARD)

2-FULL NAME A. Levin (Abraham)

(a) RESIDENCE. NO. 714 N. Fremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hulda Levin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Baltimore St.

15 MAR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1923, to March 1 1924

that I last saw him alive on March 9 1924

and that death occurred, on the date stated above, at 8, 45 9. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis. Rt Hemiplegia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn, M. D.

, 19 (Address) 2027 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	March 9 1924

20 UNDERTAKER ADDRESS

Jac. Lewis, 1439 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84668

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 D 84668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Finglas

(a) RESIDENCE NO. 1935 Orleans ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 15-193

7 AGE — Years: ✓ — Months: 6 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Bucks. (State or country) Maryland

PARENTS

10 NAME OF FATHER Morris Finglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Barrabram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant: J. Lewis
(Address) 1439 E. Baltimore

15 Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1924 to March 7, 1924.

that I last saw her alive on March 7, 1924

and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor L. Frey, M. D.

Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt. Carmel — DATE OF BURIAL: March 9 1924

20 UNDERTAKER: Jac J. Lewis — ADDRESS: 1439 E. Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84669

91-002 ✓

CERTIFICATE OF DEATH.

D 84669

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 140 Wilson St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine McElroy

(a) Residence No. 140 Wilson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James W. McElroy

6-DATE OF BIRTH (month, day and year) Mar. 9, 1842

7-AGE. 81 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Anthony Bonn

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Eliza Ann Ring

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs. Ernest S. McElroy

(Address) York Road, Near Towson, Md

15- Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 24th 1924 to March 8th 1924

that I last saw h.. alive on March 7th 1924

and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Senile gangrene (Both feet and legs)

(Duration) ✓ yrs. ✓ mos. 14 ds.

CONTRIBUTORY (Secondary) Senile arteriosclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) E. W. Blanchfield, M. D

3.8. 1924 (Address) 1515 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	3/10 19 24
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84670

CERTIFICATE OF DEATH.

11-60 D 84670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 Ashland Ave ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Rolle

(a) RESIDENCE NO. 2040 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. 6 mos. 5 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Gerard E. Rolle

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Helen M. Slaters

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Gerard E. Rolle

(Address) 2040 Ashland Ave

Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1 1924 to March 8 1924

that I last saw her alive on March 8 1924

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pyelitis

acute Bronchitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. F. Friedenwald, M. D.

19 (Address) 800 N. Mont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery | DATE OF BURIAL March 10 1924

20 UNDERTAKER Henry Hoeck Son | ADDRESS 1341 E Eager St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84671

CERTIFICATE OF DEATH.

101-001

D 84671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Cypress ST.; 25 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wojeicteci

(Residence in Baltimore: No. 5 Cypress St.: 15 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 4, 1876 (Month) (Day) (Year)

7-AGE, 47 yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Moulder's Help.
(b) General nature of industry, business, or establishment in which employed (or employer): Ot

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Alexander Wojecicki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THF ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Konstanty Olesanzza

(Address) 24 Elm St.

15-

Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 7, 1924 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 7 1924, to March 7 1924, that I saw h— alive on March 7 1924, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pulmonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. J. Hartica M. D.

March 8, 1924 (Address) Curtis Bay, Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross A A 60. DATE OF BURIAL, 3/10, 1924

UNDERTAKER Wm Trautwein ADDRESS 1018 Eastern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84672 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84672

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S Bethel ST. V WARD)

2-FULL NAME Antonina Raczynski (Kuta)

(a) RESIDENCE No. 308 S. Bethel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
About	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework. 07

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frank Pilch (Address) 308. S. Bethel

15 Filed MAR 9 - 1924 Burial Permit Clerk... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1924, to March 6, 1924, that I last saw her alive on March 5, 1924, and that death occurred, on the date stated above, at 1.25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. J. Barr M. D.

3.8. 1924 (Address) 811 S. Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 3/10 1924

UNDERTAKER Wm Gallagher & Co — ADDRESS 1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84673

CERTIFICATE OF DEATH.

52 D 84673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST., 14 WARD)

2-FULL NAME James Dunn Jr.

(a) RESIDENCE (Usual place of abode) NO. 1524 Madison Ave ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) newyork.

PARENTS

10 NAME OF FATHER James B. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Marie Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mississippi

14 Informant James B Dunn

(Address) 1419 Madison Avenue

15 MAR 9 - 1924 ROBERT R. KRAUTER, Registrar

Social Service Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-24 19

17

I HEREBY CERTIFY, That I attended deceased from 2-24-24, 19, to 3-7-24, 19, that I last saw h alive on 3-7-24, 19, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy
Endocarditis
Myocarditis, Rheumatic

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dil.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Jno A Washington M. D.

3-7, 24 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. DATE OF BURIAL: Mar. 10 1924

20 UNDERTAKER: Wash B. Cook ADDRESS: 1003 N. Dals

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84674

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1933 Christian St. 20 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice L. Croghan

(a) Residence No. 1933 Christian St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 9 1923

7-AGE, ...yrs. 8 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry F. Croghan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth McGraw

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mrs. Elizabeth M. Croghan

(Address) 1933 E. Baltimore St.

15- MAR 9 - 1924 ROBERT P. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 8-1924

17- I HEREBY CERTIFY, That I attended deceased from March 8, 1924 to March 8, 1924

that I last saw h.r alive on March 8, 1924

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raphael H. Isaacs M. D.

, 19 (Address) 1827 E. Baltimore st.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn Cem. | DATE OF BURIAL, March 11, 1924

20-UNDERTAKER Peter F. Cowan & Son | ADDRESS Peter F. Cowan 1911 Hollins St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84675

CERTIFICATE OF DEATH.

X 129

D 84675

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maggie Worrell

(a) Residence No. Woodlawn Md St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Asha Worrell

6-DATE OF BIRTH (month, day and year) Aug 10 63

7-AGE. 60 yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

037

9-BIRTHPLACE (city or town) (State or Country), Balto, Md

PARENTS

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

11-Informant Asha Worrell

(Address) Woodlawn Md

15-Filed MAR 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 7-1924

17-I HEREBY CERTIFY, That I attended deceased from March 6 19 24 to March 7 19 24

that I last saw h[illegible] alive on March 7 19 24

and that death occurred, on the date stated above, at 12 20 AM

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Chronic Nephritis.

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. Goldenson M. D.

19 (Address) Asst - Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cem — DATE OF BURIAL. March 10 1924

20-UNDERTAKER, W M Routson — ADDRESS 2238 N Howard

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84676

HEALTH DEPARTMENT—CITY OF BALTIMORE

904 84676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., [illegible] Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Smith

(a) Residence No. Baltimore City Jail St., Ward 2/16 Rock N.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: 60? yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS:

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14-

(Informant) City Hospital

(Address)

15- MAR 10 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-6-24

17- I HEREBY CERTIFY, That I attended deceased from February 12, 1924 to March 6, 1924

that I last saw her alive on March 6, 1924

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic myocarditis

myocardial degeneration

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub

(Signed) Claude A. Dana, M. D.

3-7, 1924 (Address) Municipal Hospitals

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	March 9 1924
20-UNDERTAKER,	ADDRESS 119 N.
Brown & Sons	Funeral Directors

N. B.—WHITE PAPER, WHITE INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84677

CERTIFICATE OF DEATH.

D 84677

1-PLACE OF DEATH University Hospital. REGISTERED NO. 117

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Santoni.

(a) RESIDENCE NO. 731 W. Saratoga St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/10/1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. At school.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Colorado.

PARENTS

10 NAME OF FATHER Vincent Santoni

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER D'anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Ignacio Santoni (Address) 731 W Saratoga

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

MAR 1 0 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 1. 1924, to March 6. 1924, that I last saw him alive on March 6. 1924 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes. Date of March 1st 1924

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) David R Nevarre, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral	3/10/ 1924
20 UNDERTAKER	ADDRESS
J. S. Fahey & Sons	1315 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84678 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84678

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 662 W. Fayette ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sate A Stutchins

(a) RESIDENCE. No. 662 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Lft yrs. mos. ds. How long in U. S., if of foreign birth Lft yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Robert H Hutchins

6 DATE OF BIRTH (month, day, and year) Apr 28, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Lee

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Cecelia Koontz

13 BIRTHPLACE OF MOTHER (city or town) Ware
(State or country) Ga

14 Informant Carrie M Hutchins
(Address) 662 W Baltimore St

MAR 10 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1924, to March 7, 1924, that I last saw h 24 alive on March 7, 1924, and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Mytral Regurgitation &
Terminal Pneumonia

(duration) 5 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Chronic Nephritis (duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination, Chest & Clinical

(Signed) C. H. Cluff M. D.

3/8, 1924 (Address) 312 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lanvale Park	March 12 1924
20 UNDERTAKER' William Cook	ADDRESS 502 Mulberry

N. B.—WRITE PLAINLY WITH LEAD PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 / D 84679

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 11 WARD)

2-FULL NAME Alexander A. Smith

(a) RESIDENCE NO. 730 Lindenave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Smith

6 DATE OF BIRTH (month, day, and year) July 14, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel A. Smith

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah F. Jones

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Sarah F. Smith
(Address) 730 Linden Ave

15 MAR 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hennessy, M. D.
(Coroner.)

March 9, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. | DATE OF BURIAL 3-11 1924

20 UNDERTAKER George T. A. Gibson | ADDRESS 1735 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84680

CERTIFICATE OF DEATH.

74-001 D 84680

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 612 N. Montford Ave (Ward) 7

2-FULL NAME Laura V. Ritter

(a) RESIDENCE No. 615 N. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Ritter

6 DATE OF BIRTH (month, day, and year) July 8-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housedutes

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Muth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Mrs Casper Hohman

(Address) 615 N. Potomac St

MAR 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1924

17

I HEREBY CERTIFY, That I attended deceased from February, 1924, to March 7, 1924, that I last saw her alive on March 7, 1924, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorhage

(duration) yrs. mos 2½ ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

March 9, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Mar 10 1924
20 UNDERTAKER	ADDRESS
Geo M Enst Son	811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84681

HEALTH DEPARTMENT—CITY OF BALTIMORE

179

D 84681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1906 W. Mulberry St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Frissell

(a) Residence No. 1906 W. Mulberry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas Frissell

6-DATE OF BIRTH (month, day and year) March 20, 1853

7-AGE, 70 yrs. 11 mos. 2 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Poulton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Alvina Mason

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mrs Jannie E. Frissell

(Address) 1906 W. Mulberry st

MAR 10 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1924, to Mar. 8, 1924, that I last saw her alive on Mar. 7, 1924, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Rheumatic

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Whiting Strong, M. D.

3/8, 1924 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, March 11, 1924

20-UNDERTAKER, George J Smith — ADDRESS 1532 Hollins

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S —400 Bks.

D 84682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84682

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3227 Fait ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Pauline James

(a) Residence No. 3227 Fait ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas. James

6-DATE OF BIRTH (month, day and year) Aug. 2-1856

7-AGE. 67 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Aug. Schmidt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), not known

11- (Informant) Chas. James

(Address) 3227 Fait ave

15-

Filed MAR 10 1924 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/7-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 25, 1923, to March 7, 1924

that I last saw her alive on March 7, 1924,

and that death occurred, on the date stated above, at 10.25 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis + Bronchitis (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) C. O. Reifschneider, M. D.

2/8, 1924 (Address) 2939 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Schwartz's Cemetery — DATE OF BURIAL, 3/10, 1924

20-UNDERTAKER, Zinkler + Zinkler — ADDRESS 1739 E. Eager St.

N. B.—WHEN FILLING OUT THIS CERTIFICATE, WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84683

CERTIFICATE OF DEATH.

90 D 84683

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 Aisquith St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kasriel Goldsmith

(a) Residence No. 109 Aisquith St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 90 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Edel Goldsmith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Bert Dankberg

(Address) 1735 E. Baltimore St.

15- Filed MAR 10 1924 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/10/24

17- I HEREBY CERTIFY, That I attended deceased from March 8 19 24 to 3/9 19 24

that I last saw him alive on March 9 19 24

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm F Boyden M. D.

3/10, 19 (Address) 20 N Gilmor

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale DATE OF BURIAL, 3/10 19 24

20-UNDERTAKER, Sol Levinson ADDRESS 1124 E Balto st

N. B.—WRITE PLAINLY WITH UNFADING INK. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84684

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Home

Registered No.....

City of BALTIMORE: (No. 3409 Morris Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Ada Horwitz

(a) Residence No. 3409 Morris Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (Write the word.) married

5a-If married, ~~widowed~~, or ~~divorced~~, ~~HUSBAND of~~ (or) WIFE of Jacob Horwitz

6-DATE OF BIRTH (month, day and year) April 8, 1858

7-AGE. 65 yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) Minsk (State or Country) Russia

PARENTS.

10-NAME OF FATHER, Hirsh Greenberg

11-BIRTHPLACE OF FATHER (city or town) Minsk (State or Country) Russia

12-MAIDEN NAME OF MOTHER, Bertha —

13-BIRTHPLACE OF MOTHER (city or town) Minsk (State or Country) Russia

14- (Informant) Daughter

(Address) 3409 Morris Ave

15- Filed MAR 10 1924 192 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 9, 19 24 to Mar 9, 19 24

that I last saw her alive on Mar 8, 19 24

and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) 1 yrs. 11 mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auricular fibrillation

(Signed) Aaron Robinson, M. D

3/10, 19 24 (Address) Alhambra Apts.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Washington — DATE OF BURIAL, 3/10, 19 24

20-UNDERTAKER. Sol Simmons & Co — ADDRESS 1127 E Balto St

I. Be sure every question is answered. Data should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S.A.E.

D.A.K.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84685 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

49 D 84685

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 N Patterson Park Ave ST., 7 WARD)

2-FULL NAME Henry Holdefer

(a) RESIDENCE No. 803 N. Patterson Pk Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Elizabeth Holdefer

6 DATE OF BIRTH (month, day, and year) Feby 14th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Holdefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Rupert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Holdefer
(Address) 803 N. Patterson Park Ave

15 MAR 10 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9- 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept- 1923, to March 9 1924.
that I last saw h— alive on March 8- 1924
and that death occurred, on the date stated above, at 3.30 a. m.
The CAUSE OF DEATH* was as follows:

Malignant dis. Prostate Gland.

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos A Bowles, M. D.

19 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 12th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument 24

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84686

CERTIFICATE OF DEATH.

96 D 84686

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 Aisquith ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Smith

(a) RESIDENCE NO. 716 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J C Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Henrietta Malinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lamertine M Smith

(Address) 716 Aisquith St

15 Filed MAR 10 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/1924

17 I HEREBY CERTIFY, That I attended deceased from March 7th, 1924, to March 8th, 1924, that I last saw h. alive on March 8th, 1924, and that death occurred, on the date stated above, at about 6 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Wm J. Lucaweed M. D.

3/8/1924 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: March 11th 1924

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1125 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84687

HEALTH DEPARTMENT—CITY OF BALTIMORE

84687

CERTIFICATE OF DEATH.

100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Binney St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Milton McClellen Lawrence

(a) Residence No... 1105 Binney St. St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 28-1922

7-AGE.	If LESS than 1 day,
1 yrs. 3 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, John Schaf

11-BIRTHPLACE OF FATHER (city or town). U. S.
(State or Country),

12-MAIDEN NAME OF MOTHER, Augusta Lawrence

13-BIRTHPLACE OF MOTHER (city or town). Balto. Md.
(State or Country),

14-

(Informant). Augusta Lawrence

(Address)..... 1105 Binney St.

15-

MAR 10 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mch 6th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 4 1924 to March 6 1924

that I last saw h. living on March 6 1924

and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Primary)

.....(Duration)..... yrs. ..... mos. 5 ds.

CONTRIBUTORY
(Secondary)

.....(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. J. McAvoy, M. D

Mch 7. 1924 Address 839 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem	Mch 10th 1924
20-UNDERTAKER,	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 D 84688

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 15 ST., ... WARD)

2-FULL NAME Meyer Berman

(a) RESIDENCE NO. 627 Cumberland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Era Berman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Leurs
(Address) 1439 Eutaw St.

15 MAR 10 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1923 to 3/9, 1924.

that I last saw h[illegible] alive on 3/9, 1924

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidor S. Fry, M. D.

Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 3/10 1924

20 UNDERTAKER Jack Leurs

ADDRESS 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84689

74-001 ✓

D 84689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2438 Lakeview ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Morris Steedle

(a) Residence No. 2438 Lakeview ave St., Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 3 Y yrs. mos. ds. How long in U. S., if of foreign birth? 3 Y yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Bessie Steedle

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Real Estate

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Philip Steedle

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Mollie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jack Lewis

(Address) 1439 E Baltimore

15- MAR 1 0 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/10/24

17- I HEREBY CERTIFY, That I attended deceased from March 8th 19.24 to March 10 19.24

that I last saw h[illegible] alive on March 10 19.24

and that death occurred, on the date stated above, at 7.40 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1/2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Nubel A. Abrams M. D.

March 10, 1924 (Address) 1360 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Fleischmann Co	3/10, 19.24
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 84690

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) 1725 Eutaw

2-FULL NAME James Nelson Williams

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 23 - 75

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER C. N. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Mary Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Records of Mt Hope Retreat Baltimore Md.

15 MAR 10 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1924, to March 6th, 1924, that I last saw deceased alive on March 6th, 1924, and that death occurred, on the date stated above, at abt 9. P. m.

The CAUSE OF DEATH* was as follows:

Augma Pectoris.

Suddenly (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dept. Psychosis.

abs (duration) 1 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Mch 7, 1924 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: 3/10/1924

20 UNDERTAKER: George J Rath — ADDRESS: 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

17026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84691

CERTIFICATE OF DEATH.

100-001

D 84691

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Jones

(a) RESIDENCE NO. 122 S. Caroline ST. WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred hosp mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lilly Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1924 to Feb 29 1924
that I last saw him alive on Feb 29 1924
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:

Thoracic rickets

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? 122 S. Caroline St.

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? — Autopsy

(Signed) H. H. Wood, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Mar 9 1924
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

19

1216

Spec—12-23-21—E.B.R.S.—400 Bks.

Bushey

D 84692 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓

CERTIFICATE OF DEATH.

90 D 84692

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mater Misericordiae St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Catherine Bushey

(a) Residence No. Laval & Eutaw Sts. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE. White | 5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J Bushey

6-DATE OF BIRTH (month, day and year) May 4-1840

7-AGE. 83 yrs. 10 mos. 6 ds. | If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Frederick County Md
(State or Country)

PARENTS.

10-NAME OF FATHER Daniel Bibb

11-BIRTHPLACE OF FATHER (city or town) Frederick Co
(State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Bibb

13-BIRTHPLACE OF MOTHER (city or town) Frederick Co
(State or Country) Md

11-

(Informant) Mrs. J. Bushey

(Address) Mater Misericordiae

15-

Filed MAR 1 0 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 9 1924

17- I HEREBY CERTIFY, That I attended deceased from March 4 19 24 to March 9 19 24

that I last saw h.. alive on March 9 19 24,

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Acute Cardiac Dilation

(Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas. Schaffner M. D

19 (Address) 1301 Mulberry St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemt Frederick Md | DATE OF BURIAL: Mar 12 1924

20-UNDERTAKER: Putnam & Cox | ADDRESS: 1723 N. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Grobaker. ✓

D 84693 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84693

CERTIFICATE OF DEATH. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine K. Grobaker.

(a) RESIDENCE No. 3 N. Pearl St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow Anderson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Marie Yaeger

(Address) 604 N. Pearl St

15 Filed MAR 1 0 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1 1924, to March 8 1924, that I last saw h[illegible] alive on March 8 1924, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? Yes Date of March 7, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. R. Wearn, M. D.

. 19 (Address) 4005 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL March 10th 1924

20 UNDERTAKER A. Jones — ADDRESS 111 S Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-801 ✓ 74-D 84694

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 420 Tuxedo St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Edward T. Reinhart

(a) Residence No. 420 Tuxedo St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Reinhart

6-DATE OF BIRTH (month, day and year) March 17 1874

7-AGE, 50 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer. Potts Engineering Co.

9-BIRTHPLACE (city or town) (State or Country). Wilmington Del.

PARENTS.

10-NAME OF FATHER. John Reinhart

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Wilmington Del

12-MAIDEN NAME OF MOTHER. Wolbourn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Wilmington Del

14- (Informant). Anna E. Reinhart

(Address) 420 Tuxedo St.

15- MAR 10 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 10 24

I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 10, 1924, that I last saw him alive on March 10, 1924, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. C. Richardson M. D.

3/10/24 (Address) 1120 W. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore County March 13 24 — DATE OF BURIAL.

20-UNDERTAKER. Wilhelm Bros & Nuttle — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Wm J Chard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84695

CERTIFICATE OF DEATH.

181-001

D 84695

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 641 W. Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. J. Chard

(Residence in Baltimore: No. 641 W Lexington St; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W	S

6-DATE OF BIRTH. June (Month) 24 (Day) 1860 (Year)

7-AGE. 63 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer): 680

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. William O'Chard

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Andrews

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M Fowler

(Address) 914 W Fayette

15- Filed MAR 10 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mch. (Month) 8 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy on~~ Inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, au-~~ ~~topsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Insulation of Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Fowler M. D. (Coroner.)

3-10 1924 (Address) 117 N Dallas

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	March 10 1924
20-UNDERTAKER. W M Routson	ADDRESS 2235 W North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 84696

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84696

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. United States N. Charles St., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Cummings
Sutherville Md

(a) RESIDENCE NO..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Md.	col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa E Cummings

6 DATE OF BIRTH (month, day, and year) Apr. 8. 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) M.E.
(c) Name of employer

9 BIRTHPLACE (city or town) Balt City
(State or country)

PARENTS

10 NAME OF FATHER Henry Cummings

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Savage

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ida Cummings
(Address) 1234 Druid Hill Ave

15 Filed MAR 1 01924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) ... (Coroner.) ... M. D.
March 10, 192 4 (Address) 16 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Few minutes
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	3/10 192 4

20 UNDERTAKER Samuel T. Hemsley ADDRESS 1718 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84697

CERTIFICATE OF DEATH.

6 × 90 D 84697

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 8 N. Potomac St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret O. Eckholme

(a) Residence No. 2799 E. 11th St., Brooklyn, N.Y. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles O. Eckholme

6-DATE OF BIRTH (month, day and year) May 1, 1865

7-AGE. 59 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore Md.
(State or Country),

PARENTS.

10-NAME OF FATHER. Richard Rowntree

11-BIRTHPLACE OF FATHER (city or town). England
(State or Country),

12-MAIDEN NAME OF MOTHER. Rebecca Browning

13-BIRTHPLACE OF MOTHER (city or town) Balt. Md.
(State or Country),

14- (Informant) Mrs. Charles O. Eckholme

(Address) 2799 E. 11th St. Brooklyn N.Y.

MAR 10 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 6, 1924 to March 9, 1924 that I last saw her alive on March 7, 1924 and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Brooklyn N.Y.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? P.S.V.S.

(Signed) John J. Kruger M. D.

, 19 (Address) 2622 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery DATE OF BURIAL. March 13 1924

20-UNDERTAKER. Henry Horde Son ADDRESS 301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84698

CERTIFICATE OF DEATH.

100-001 ✓

REGISTERED No. D 84698

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 N. Carey ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bettie Burley

(a) RESIDENCE. No. 720 N. Carey ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Burley

6 DATE OF BIRTH (month, day, and year) — — 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond, Virginia

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Chisum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Susie Johnson

(Address) 720 N. Carey

MAR 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1924, to Mar 8th, 1924, that I last saw h e alive on Mar. 8th, 1924, and that death occurred, on the date stated above, at 4:10 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) Isabel Bede, M. D.

, 19 (Address) 1127 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery.	March 11 1924
20 UNDERTAKER Mrs James H. Dennis	ADDRESS 1303 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84699

Registered No. 10 33

1-PLACE OF DEATH

City of BALTIMORE: (No. 708 Forrest St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Mullen

(a) Residence No. 708 Forrest St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Mulleh

6-DATE OF BIRTH (month, day and year) Feb. 4th. 1855

7-AGE: 69 yrs. 1 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Timothy Shay

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Donovan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Miss Mullen

(Address): 708 Forrest St.

15- MAR 10 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 7/24.

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 19 24 to Mch 7, 19 24

that I last saw her alive on Mch 7, 19 24

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hazard M. D

3/10, 1924 (Address) 225-W Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery.	March 11 1924.
20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	118 W. Mt. Royal Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 84700

CERTIFICATE OF DEATH.

D 84700

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3723 Clairmount St. No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Frado

(a) RESIDENCE. No. 3723 Clairmount St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred X yrs. X mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch. 9. 24

7 AGE	Years	Months	Days	If LESS than 1 day, / hrs. or ___ min.
	X	X	X	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Fistiandtown

PARENTS

10 NAME OF FATHER Anthony Frado

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Castle Pa

12 MAIDEN NAME OF MOTHER Anna Gruko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penton Pa

14 Informant Anthony Frado Sr.
(Address) 3723 Clairmount Ave

15 Filed MAR 10 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 9. 1924

17

I HEREBY CERTIFY, That I attended deceased from Mch 9 19 24 to Mch 9 19 24

that I last saw h[illegible] alive on Mch 9 19 24

and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

X (duration) X yrs. X mos. 1/2 ds.

CONTRIBUTORY (Secondary) Premature Birth X (duration) X yrs. X mos. 1 hr ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Wm. L. Tennant M. D.

Mch 9 19 24 (Address) 2485 3d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Mch 10 1924

20 UNDERTAKER Lilly and Zeile

ADDRESS 403 S. Wolfe St.

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84701

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N Monroe ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa ann F McDonnell

(a) RESIDENCE No. 113 N Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John P McDonnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth McLellan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John P McDonnell (Address) 113 N Monroe st

15 MAR 10 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to March 9, 1924, that I last saw her alive on March 9, 1924 and that death occurred, on the date stated above, at 11.10 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 6. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar E. Powers, M. D.

19 (Address) 1520 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	10/2 1924
20 UNDERTAKER Cathedral	ADDRESS
George A. Farley	1800 W Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84702

CERTIFICATE OF DEATH.

3| D 84702

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 Mace St., 17 WARD)

2-FULL NAME William Freed

(a) RESIDENCE NO. 2208 Mace St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Maryland Penitentiary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Fannie Freeman

(Address) 2208 Mace St

15 Date: MAR 10 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924, to March 9 1924, that I last saw him alive on March 9, 1924, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Tuberculosis)

(duration) ? yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Genito Urinary

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Jas F Dale, M. D.

, 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: March 11 1924

20 UNDERTAKER: Jesse Redden — ADDRESS: 436 N. Bdwy

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84703

CERTIFICATE OF DEATH.

99-001 ✓

D 84703

1-PLACE OF DEATH

City of BALTIMORE: (No. #6 Longwood R'd St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W Lucy

(a) Residence No. #6 Longwood R'd St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Ellie Pollard Lucy

6-DATE OF BIRTH (month, day and year) Aug 17 1841

7-AGE. 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cash Register

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Howard Co Md

PARENTS

10-NAME OF FATHER Thomas Lucy

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England

12-MAIDEN NAME OF MOTHER Mary E Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

11- (Informant) Milton M Lucy

(Address) #6 Longwood R'd

15-

Filed MAR 10 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 9 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to March 9 1924

that I last saw h.. alive on March 8 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Immediate

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. 6 hrs

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) E. F. Thorn M. D

3-30. 1924 (Address) 811 N. Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. Mch 11 1924

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

NOTICE—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84704

CERTIFICATE OF DEATH.

X 12 D 84704

1-PLACE OF DEATH Howard A. Kelly Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Eutaw Pl ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret D Morgan

(a) RESIDENCE NO. 612 Avery St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James G. Morgan

6 DATE OF BIRTH (month, day, and year) March 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Wheeling W. Va. (State or country)

PARENTS

10 NAME OF FATHER Thomas Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Haffey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Henry Daly (Address) Parkersburg W. Va

15 Filed [illegible] Registrar

MAR 10 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 3, 1924, to Mar 9, 1924, that I last saw her alive on Mar 9, 1924, and that death occurred, on the date stated above, at 2 45 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - (Mitral Stenosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation for Gall-Bladder Sinus

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Parkersburg W Va

Did an operation precede death? Yes Date of Mar 4th 24

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) William Field Jr. M. D.

3-9, 1924 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkersburg W. Va — DATE OF BURIAL: March 11 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. Fayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 84705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84705

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH (Linden & Chauncey Aves)

Registered No.....

City of BALTIMORE: (No. Brooks Hall Apts. 2 B. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Benjamin Perlman.....

(a) Residence No..... Brooks Hall Apts. ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Male	White	Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Perlman

6-DATE OF BIRTH (month, day and year)

7-AGE. ..64... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Leaf Tobacco
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 045
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Moses Perlman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia.

12-MAIDEN NAME OF MOTHER, Rachel Schwartz Apple

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Russia.

14- (Informant) Joseph Perlman

(Address) Brooks Hall Apts.

15- Filed ..... Robert P. Harrison, Registrar.

MAR 10 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/10/24.

17- I HEREBY CERTIFY, That I attended deceased from May 1 1923 to Mar 10 1924 that I last saw h/ alive on Mar 9 1924 and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of Tongue

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) J. M. Dellett M. D

. 19 (Address) 621 Washington Bldg.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oheb Shalom Cem.	3/11/ 24.

20-UNDERTAKER.	ADDRESS
David Sandheim	115-20 W. Mt. Royal Ave.

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84706

CERTIFICATE OF DEATH.

1924 D 84706

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Travers.

(a) RESIDENCE No 1709 Patapsco St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced
(or) WIFE of Sewell Travers.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Floyd Smith.
(Address) 1219 E. Lombard St.

15 Filed MAR 10 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autho (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute peritonitis due to perforation of the Uterus. Self inflicted?

General Sepsis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Wilbur Reinhardt, M. D. (Coroner.)

Mch, 10, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md Cha Cem Co	Mar 10, 1924
20 UNDERTAKER John F Denny	ADDRESS 716 Light St

GE should be stated EXACTLY. PHYSICIANS ... it may be properly classified. Exact statement ... OCCUPA-
CAUSE OF DEATH in plain terms, so that it ...
TION is very important. See instructions on b... on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84707

CERTIFICATE OF DEATH.

31 ✓ D 84707

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Whatcoat ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Young

(Residence in Baltimore: No. 1309 Whatcoat St.; 42 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colord

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Cook

9-BIRTHPLACE, (State or Country) St Marys Co

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Henretter Young

13-BIRTHPLACE OF MOTHER (State or Country), St-Marys Co

14-THE ABOVE IS TRUE TO THE BEST OF MY ~~KNOWLEDGE~~.

(Informant) Mrs R A Elliott

(Address) 1725- Ashland Ave

15- MAR 11 1924 ROBERT R. KRAUTER, Burial Permit ~~Clerk~~.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 8 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febry 29 1924, to Mch 8 1924, that I saw her alive on Mch 7 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic Old track

(Duration) ✓ yrs. 6 mos. ✓ ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) ✓ yrs. ✓ mos. 7 ds.

(Signed) George C. Brannen M. D.

3/10, 1924 (Address) 707 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery DATE OF BURIAL, March 11, 1924

20-UNDERTAKER Mrs Robert A Elliott ADDRESS 1725- Ashland Ave

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 84708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 84708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Berl

(a) RESIDENCE No. 3441 Jenkins Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Late Wm J. Berl

6 DATE OF BIRTH (month, day, and year) May 14/73

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Berl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Helen Berl
(Address) 3441 Jenkins Ave

15 MAR 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Elbow (accidental fall)

Fridays (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Embolism and Sen. (duration) yrs. mos. ds.

(Signed) Wm J. Riley, M. D.
(Coroner.)

Mch 10, 1924 (Address) 1038 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Fridays

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL 3/11 1924

20 UNDERTAKER Philip Herrig ADDRESS 2016 Orleans

MARNING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84709

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5012 Dennore Ave ST. 27 WARD)

2-FULL NAME Katherine Lehr

(a) RESIDENCE No. 5012 Dennore Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.
(If non-resident, give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years (unknown) Months Days — If LESS than 1 day, ... hrs. or ... min.
Between 75 & 80 yrs.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): Housework
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown (America)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): — unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): — unknown

14 Informant Mrs M M Trostman
(Address) 5012 Dennore Ave

15 MAR 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Mch 10, 1924, that I last saw h[illegible] alive on Mch 10, 1924, and that death occurred, on the date stated above, at 1 20 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) ... yrs. 18 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles J Wells, M. D.

, 19 (Address) 711 Belvedere Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Mar 12 1924

20 UNDERTAKER: Harry W. Ehlen

ADDRESS 1944 W North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84710

CERTIFICATE OF DEATH.

40 D 84710

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 215 W Hamburg ST., 23 (WARD)

2-FULL NAME Arnold Taylor

(a) RESIDENCE NO. 215 W Hamburg ST., 23 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: Col — 5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/27/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer: Swindell Glass Co.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Geo Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emmeline Wales

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Rose Taylor
(Address) 215 W. Hamburg St

15 MAR 11 1924 ROBERT N. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/1/1924 to 3/7/1924 that I last saw him alive on 3/7/1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart (duration) Abt 3 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Guy Bowley, M. D.

3/8/24, 19 (Address) 908 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3/11 1924
20 UNDERTAKER: Samuel Wensley	ADDRESS: Wzille

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84711

38 D 84711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 W. Mulberry ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Fowler

(a) RESIDENCE NO. 742 W. Mulberry ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Fowler

6 DATE OF BIRTH (month, day, and year) June, 1, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore 14 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Fowler

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Olivia Bordley

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Annie Fowler

(Address) 742 W Mulberry

15 [illegible]

MAR 11 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 18, 1924, to Mar, 8, 1924, that I last saw him alive on Mar, 6, 1924, and that death occurred, on the date stated above, at 6 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic + Mitral Endocarditis

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

CONTRIBUTORY (Secondary) —

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Frankel, M. D.

3/8 1924 (Address) 1122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3-10 1924

20 UNDERTAKER John H Trader — ADDRESS 1412 Lexington St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84712

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 84712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Sherwood

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Sarah C. Sherwood

6-DATE OF BIRTH (month, day and year) 3-13-1842

7-AGE. 81 yrs. 11 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Can maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, William Sherwood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, ? Wertz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Ella Sherwood

(Address) 2435 E Federal St

15- Filed. MAR 11 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/9/24

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to March 9, 1924, that I last saw him alive on March 9, 1924, and that death occurred, on the date stated above, at 7-15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arthritis Stricture, Urinary Fistula Cystitis (Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No. Date of 6/28. 9/15/23. 3/5/24.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Wm. J. Faulton M. D

. 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 3/12 19 24
U. S. National	
20-UNDERTAKER, WJS Corp	ADDRESS 502 E Nath.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 84713

CERTIFICATE OF DEATH.

B 84713

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. 100-09

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Lindsay

(a) RESIDENCE NO. 1248 N. Gay St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Lindsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Livia Brumgle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1924, to March 9, 1924,

that I last saw h.. alive on March 9, 1924,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Broncho pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Sudden death - unexplained

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	March 19 24

20 UNDERTAKER John J. Feldt ADDRESS 1200 N. Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84714

CERTIFICATE OF DEATH.

100 081 84714

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 W. Saratoga St. 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Romaine Burrell

(a) Residence No. 1010 W. Saratoga St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 17-1922

7-AGE, 1 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Theodore Burrell

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Helen Lenia Snell

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country), Md.

14-(Informant)..... Clara Angust

(Address)..... 1010 W. Saratoga St.

15-Filed MAR 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 9-1924.

17-I HEREBY CERTIFY, That I attended deceased from March 8- 1924 to March 9- 1924 that I last saw h. alive on March 8- 1924, and that death occurred, on the date stated above, at 12:40 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) none

.....(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Ruland, M. D.

3-10, 1924 (Address) 2532 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Calvary Cem — DATE OF BURIAL, 3-12, 1924

20-UNDERTAKER, David Eastburn — ADDRESS 776 Cam

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84715

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 84715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 834 W. Ostend St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stewart

(a) Residence No. 834 W. Ostend St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female — 4-COLOR OR RACE, Blk — 5-Single, Married, Widowed or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 14. 1902

7-AGE 22 yrs. 1 mos. 24 ds. — If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work N. W.
(b) General nature of industry, business, or establishment in which employed (or employer) 670
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.
10-NAME OF FATHER, Andrew Stewart
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Charlotte Williams
(Address) 1013 Booth

15- MAR 1 1924
Filed ....., 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-1-24

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 24, 19.., to Mar 8 24, 19.., that I last saw h. alive on Mar 8. 24, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

8
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? None

What test confirmed diagnosis? .....

(Signed) Wm J Schwartz, M. D.

(Address) 1 Newington Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL, 3-4-24

20-UNDERTAKER David Forbes — ADDRESS 6a and

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84716

CERTIFICATE OF DEATH.

574-001

D 84716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 N. Vincent ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren Toles

(a) RESIDENCE. NO. 1425 N. Vincent ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Toles.

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lancaster County Va.

PARENTS

10 NAME OF FATHER Cook Toles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster County, Va.

12 MAIDEN NAME OF MOTHER Mary Montague 3/8/24

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster County, Va.

14 Informant (Address) Agnes L. Walker 1622 N. Bruce St.

15 Filed MAR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 7, 1924, that I last saw h.e alive on " " , 1924, and that death occurred, on the date stated above, at 4 50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) None — 9

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 1425 N. Vincent St.

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) John D. Dutton, M. D.

(Address) 501 N. Dutton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	3-11-24
20 UNDERTAKER	ADDRESS
David Carter	Laurel

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84717

CERTIFICATE OF DEATH.

D 84717

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 Myrtle ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jane Washington

(a) Residence No. 1219 Myrtle ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Mar. 8 1892

7-AGE: 32 yrs. mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia U. S.

PARENTS.

10-NAME OF FATHER: Wm Prescott

11-BIRTHPLACE OF FATHER (city or town) (State or Country): West Indies

12-MAIDEN NAME OF MOTHER: —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): West Ind.

11- (Informant): Hattie Washington

(Address): 1219 Myrtle ave

13- Filed MAR 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3/11/24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1924 to Mar. 11, 1924

that I last saw h[illegible] alive on Mar. 10, 1924

and that death occurred, on the date stated above, at 4:15 a m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Child birth

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) John H. Johnsons M. D.

19 (Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-13-24
20-UNDERTAKER	ADDRESS
Druid Taylor	916 Pine

Spec—12-23-21—E.B.R.S.—400 Bks.

Kuie

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84718

CERTIFICATE OF DEATH.

D 84718

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Motherhouse of Notre Dame St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Anselma Kim

(a) Residence No. Bisquith St. W. Hollins Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ ~~or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 24-1838

7-AGE, 86 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer) 060

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Allegheny Pa

PARENTS.

10-NAME OF FATHER, Dominic Kim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Switzerland

12-MAIDEN NAME OF MOTHER, Anna Krumenmacher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Switzerland

14- (Informant) Sister Mary Dionede

(Address) Notre Dame Bisquith St.

15- Filed APR 11 1924 ROBERT R. KRAUSER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar- 10-1924

17- I HEREBY CERTIFY, That I attended deceased from January 2d, 19 24, to Mar 10, 19 24

that I last saw h.e.r alive on....., 19.....,

and that death occurred, on the date stated above, at 1.30 p..m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) NR

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? NO Date of.....

Was there an autopsy? NO

What test confirmed diagnosis?.....

(Signed) F. F. Kirby, M. D.

3/10, 1924 (Address) 110 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Woodlawn Cem	March 12, 19 24
20-UNDERTAKER	**ADDRESS**
Frank A. Fink	915 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE

Spec.—1-10-21—M&T—1500 Bks.

84719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 84719

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margorie Dina Hornstein

(a) RESIDENCE NO. 2429 Eutaw Pl. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., ~~if of foreign birth~~? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	m	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24/1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York city

PARENTS

10 NAME OF FATHER Benj Hornstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Elda Feldstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Jack Levis (Address) 1439 E Baltor

15 Filed MAR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17

I HEREBY CERTIFY, That I attended deceased from March, 9, 1924, to March 10, 1924, that I last saw her alive on March 10, 1924, and that death occurred, on the date stated above, at 8:40 p m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Peritonitis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of March 10, 1924.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) Howard M Kerr, M. D.

. 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New York

DATE OF BURIAL 3/11 1924

20 UNDERTAKER Jack Levis 1439 E Balto

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84720

CERTIFICATE OF DEATH.

D 84720

1-PLACE OF DEATH New Aged Home — 5 — 44

Registered No.....

City of BALTIMORE: (No. 105 Asquith St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Barnett (or) (Bernard Marke)

(a) Residence No. 105 Asquith St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE: 79 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: old ageds home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) J. Lewis

(Address) 1439 E. Baltimore

15-

Filed MAR 11 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 10-24

17- I HEREBY CERTIFY, That I attended deceased from March 8th, 1924 to March 10th 1924

that I last saw him alive on March 9 1924

and that death occurred, on the date stated above, at 7.40 P.M.

The CAUSE OF DEATH* was as follows:

Coma

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hepatic Carcinoma

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Weiner M. D.

3-11. 1924 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Arbutus Rosedale — DATE OF BURIAL, March 11, 1924

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84721

88

D 84721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia King

(a) RESIDENCE NO. 1624 E Chase St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert King

6 DATE OF BIRTH (month, day, and year) March 12-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elec Sheer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Robert King (Address) 1439 E Balto St

15 MAR 11 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroners Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ....yrs. ....mos. 1/4 ds.

CONTRIBUTORY (Secondary) no history clinically

(duration) ....yrs. ....mos. ....ds.

(Signed) J. C. T. Hennessy, M. D. (Coroner.)

March 11, 1924 (Address) 2702 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Balto

DATE OF BURIAL 3/ 1924

20 UNDERTAKER Jack Levin 1439 E Balto St

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 84722

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 84722

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 Forrest ST. 10 WARD)

2-FULL NAME Edward Mulvey Wright Jr.

(a) RESIDENCE No. 1138 Forrest ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Sing'l

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 18 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Edward Mulvey Wright

11 BIRTHPLACE OF FATHER (city or town) Woodstock (State or country) Md.

12 MAIDEN NAME OF MOTHER Jeanne Thyle Otto

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr. Edward Mulvey Wright
(Address) 1138 Forrest St

15 Filed MAR 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/8, 1924, to 3/10/24, 19....,

that I last saw him alive on 3/10/24, 19....;

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Grasm) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Alma, M. D.

3/10, 1924 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock Md.	March 12 1924
20 UNDERTAKER	ADDRESS
Henry Storck Son	No 1 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84723 HEALTH DEPARTMENT—CITY OF BALTIMORE 84723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 68 Raspe Ave St., N Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leo. A. McCourt

(a) Residence No. 68 Raspe Av. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. 8 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 26 1923

7-AGE. X yrs. 8 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General natnre of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS

10-NAME OF FATHER. Leo. J. McCourt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Anna M. Hubbel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs. Leo. J. McCourt

(Address) 68 Raspe Ave.

15- MAR 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 11 1924

17- I HEREBY CERTIFY, That I attended deceased from March 3 1924 to March 10 1924

that I last saw h[illegible] alive on March 10 1924,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation over

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Benj. S. Hanglan M. D.

Mar. 11, 1924 (Address) 1216 N Castleton St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	March 13 1924
20-UNDERTAKER. Henry Storck Son	ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84724

REGISTERED NO. 100-001 D 84724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 N Caroline ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia G. Hayes

(a) RESIDENCE. No. 1615 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 24 1923

7 AGE: Years — Months: 8 — Days: 9 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Walter Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Moton Va.

12 MAIDEN NAME OF MOTHER: Sarah Tackley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Staunton Va.

14 Informant: Walter Hayes
(Address) 1615 N Caroline St

15 Filed MAR 11 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 9 1924

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to March 9, 1924, that I last saw h alive on March 9, 1924, and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marcellus E Posey, M. D.

, 19 (Address) 1445 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 3/11/1924

20 UNDERTAKER: mrs James H Dennis

ADDRESS: 1203 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84725

CERTIFICATE OF DEATH.

D 84725

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 26 WARD)

2-FULL NAME Paul Peterson

(a) RESIDENCE NO. 604 S. 13th St ST., Highlandtown WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 23 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
X	6	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Winkler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 MAR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1924, to March 10, 1924.

that I last saw h-i- alive on March 10, 1924,

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Purulent pericarditis & empyema

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Mccah, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL 3/12 1924

20 UNDERTAKER John Ullrich

ADDRESS 2008

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84726

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 W. Saratoga ST., 4 WARD)

2-FULL NAME Ellen Gertrude Mahoney

(a) RESIDENCE NO. 719 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William P. Mahoney

6 DATE OF BIRTH (month, day, and year): 5-17-870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Chambersburg Pa

PARENTS

10 NAME OF FATHER: Daniel Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Mary Jane Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chambersburg Pa

14 Informant: William P. Mahoney

(Address): 719 W Saratoga St

MAR 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-8-1924

17

I HEREBY CERTIFY, That I attended deceased from 3/5/, 1924, to 3/8/, 1924, that I last saw her alive on 3/7/, 1924, and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of mitral & aortic Valves.

Probable (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): probable Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. L. Jackson, M. D.

MAR 8 1924, 19 (Address) 808 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cashing Cemetery	March 11 1924

20 UNDERTAKER: Mrs K G. Elliott ADDRESS: 725 Carlton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 84727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Comet ST., 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Quill

(a) RESIDENCE NO. 1125 Comet ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

5a If married, widowed, or divorced (or) WIFE of Isaac Quill

6 DATE OF BIRTH (month, day, and year) Feb 18, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jacob Free

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ida Norvell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Calvin Quill (son) 1125 Comet St

15 Filed MAR 11 1924, 19... ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1923. to March 6. 1924.

that I last saw her alive on March 5. 1924.

and that death occurred, on the date stated above, at 6.45 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

3/6. 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 11 1924
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 17 C S Caulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84728

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Willax Ave., Raspeburg ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella A. Huhn,

(a) RESIDENCE No. 11 Willax Ave., Raspeburg ST., WARD 26
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Edward C. Huhn

6 DATE OF BIRTH (month, day, and year) Apr. 12, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Thomas Gibson

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Eva Anne Bosshardt

13 BIRTHPLACE OF MOTHER (city or town) Lancaster, (State or country) Penna.

14 Informant Mrs. Annie E. Lee, (Address) 83 Maple Ave., Pimlico,

15 MAR 11 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1924, to March 9, 1924, that I last saw her alive on March 8, 1924, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

3/10, 1924. (Address) 132 N. Bel Air Rd., Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: March 12, 24

20 UNDERTAKER: Frank Lassahn Son — ADDRESS: Fiddleston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—THIS IS A PERMANENT RECORD.
WRITE PLAINLY, WITH UNFADING INK.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84729
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1927 ✓ D 84729
Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Alice Ruth Disharoon

(Residence in Baltimore: No. 1002 Rutland Ave. St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. August (Month) 24 (Day) 1900 (Year)

7-AGE. 23 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).... At Home

9-BIRTHPLACE, (State or Country). Meadville, Pennsylvania

PARENTS.

10-NAME OF FATHER. Frank Otis Rider

11-BIRTHPLACE OF FATHER, (State or Country). Connecticut

12-MAIDEN NAME OF MOTHER. Frances L. Warner

13-BIRTHPLACE OF MOTHER, (State or Country). Iowa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)..... Mrs. Frances L. Ryder (Mother)
(Address)..... Norfolk, Virginia

15- MAR 11 1924 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 9 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wounds in head- entering behind left ear & left wrist- shots fired by Clarence Ray Disharoon, her husband. (Homicide) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) .....
(Duration)....yrs....mos....ds.

(Signed) J. S. K. Gallen M. D.
(Coroner.)
3-10 1924 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Norfolk Va. DATE OF BURIAL. Mar 11 1924

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Balto St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84730

CERTIFICATE OF DEATH.

D 84730

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 N. Brice St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet C. Lowe

(a) Residence No. 614 N. Brice St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George S. Lowe

6-DATE OF BIRTH (month, day and year) Oct. 1st. 1865

7-AGE. 58 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9-BIRTHPLACE (city or town) (State or Country) Queen Ann Co Md.

PARENTS.

10-NAME OF FATHER, David A. Gardner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Queen Ann Co. Md.

12-MAIDEN NAME OF MOTHER, Mary A. Goodman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Queen Ann Co. Md.

14- (Informant) Miss Carrie M. Lowe

(Address) 614 N. Brice St.

MAR 11 1924

ROBERT T. KRAUTER, Registrar.

Social Service Exhibit.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March, 9th 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 27, 1924, to March 9, 1924

that I last saw her alive on March 8, 1924

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

from Malig. (Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cronhaus M. D.

May 10 1924 (Address) 3100 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Stevensville Md. DATE OF BURIAL. March 11, 1924

20-UNDERTAKER. Fred A. B. Cook ADDRESS 1003 N. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 84731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 N. Broadway ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Francis Peyton "Cayden" G.H.

(a) RESIDENCE No. 1526 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan A. Peyton "Payden" G.H.

6 DATE OF BIRTH (month, day, and year) Mch. 14, 1843

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Peyton "Payden" G.H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Langford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Susan A. Peyton "Payden" G.H.

(Address) 1526 N. Broadway

15 Filed MAR 11 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 10 1924

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1923 to Mch 10, 1923, that I last saw him alive on Mch 9, 1923, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo Heller M. D.

3/6, 1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crisfield Md.	Mch. 11 1924
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 84732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 84732

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Snowden McCabe

(a) RESIDENCE No. 2229 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F McCabe

6 DATE OF BIRTH (month, day, and year) Dec 27 1858 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Columbus (State or country) Ohio

PARENTS

10 NAME OF FATHER Richard Snowden

11 BIRTHPLACE OF FATHER (city or town) Cadiz (State or country) Ohio

12 MAIDEN NAME OF MOTHER Martha Selby

13 BIRTHPLACE OF MOTHER (city or town) Columbus (State or country) Ohio

14 Informant Richard McCabe (Address) 2229 St Paul St

15 Filed MAR 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1924 to March 10, 1924, that I last saw h[illegible] alive on March 10, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) L. M. Pelouze M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 12 1924
20 UNDERTAKER Henry A. Jenkins Sons &	ADDRESS McCulloh & Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84733

CERTIFICATE OF DEATH.

90 D 84733

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N Calvert ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Parsons Wilson

(a) RESIDENCE No. 1023 N. Calvert St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Wilson

6 DATE OF BIRTH (month, day, and year) Nov 15 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 97

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Lorenzo Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carrollton Md

12 MAIDEN NAME OF MOTHER Ann Land

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Princess Anne Co. Va

14 Informant William H. Wilson

(Address) 1023 N. Calvert St

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

MAR 11 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MARCH 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from JANUARY 25th, 1924, to MARCH 10th, 1924, that I last saw h.r alive on MARCH 10th, 1924, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

Mch 11th 1924 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	3-11 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Son Co	Orchard and Mc Culloh

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84734

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 S. Dallas St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edward Williams

(Residence in Baltimore: No. 132 S. Dallas St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. April 1 1857
(Month) (Day) (Year)

7-AGE. 45 yrs. 11 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Carwin

(Address) 132 S. Dallas

15- MAR 11 1924 ROBERT R. KRAUTER, Registrar.
Social Purity Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 1 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ex. Laudanum

(Duration) yrs. mos. ds.

(Signed) Geo. E. Blades M. D.
(Coroner.)

March 1 1924 (Address) 143 N. Bond

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Osborn Cem.	Mar. 13 1924

20-UNDERTAKER	ADDRESS
Chas. H. Johnson	410 N. Caroline St.

Spec.—1-10-21—M&T—1500 Blks.

D 84735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 84735

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 Somerset ST. 5 WARD)

2-FULL NAME Adrian Walter Green

(a) RESIDENCE NO. 527 Somerset ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo B. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Carrie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Mother) Mrs Carrie Green
(Address) 527 Somerset St

MAR 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to March 10, 1924, that I last saw him alive on March 10, 1924, and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Backs River Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

3/10, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL March 11th 1924

20 UNDERTAKER Bonnet & Dorsch — ADDRESS 364 Cary

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84736

CERTIFICATE OF DEATH.

122-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1604 E Federal St

CITY OF BALTIMORE: (No. 1604 E Federal ST., 8 WARD)

2-FULL NAME James J. Costello

(a) RESIDENCE No. 1604 E. Federal ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary F Costello

6 DATE OF BIRTH (month, day, and year) Feb 17-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	64	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas Balto Co Md.

PARENTS

10 NAME OF FATHER Thomas Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary F. Costello

(Address) 1604 E Federal St.

Filed MAR 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Mar 10, 1924, that I last saw him alive on Mar 10, 1924, and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

(duration) 1 yrs. mos None ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical test

(Signed) A D Woodyard, M. D.

(Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL March 13 1924

20 UNDERTAKER Robt J Turner & Co — ADDRESS 1412 N. Broadway

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84737

CERTIFICATE OF DEATH.

170 D 84737

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Rutland Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Disharoon

(a) RESIDENCE NO 2104 E. Oliver St (formerly 1002 Rutland Ave) ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Ruth (Ryder) Disharoon

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver Bakery

(b) General nature of industry, business, or establishment in which employed (or employer) Delivery Wagon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berkley, Norfolk Va.

PARENTS

10 NAME OF FATHER George W. Disharoon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salisbury Md.

12 MAIDEN NAME OF MOTHER Unity Stant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilington Del.

14 Informant George E. Disharoon

(Address) 3553 11th St. Wash. D.C.

15 Filed MAR 11 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot wound in rt. temple

(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Waller, M. D.

(Coroner.)

Mar 11/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northern Cem	Mar. 12 1924
20 UNDERTAKER Richard F. Curley	ADDRESS 1108 Guilford Ave

No. 5.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84738

CERTIFICATE OF DEATH. 65-061

D 84738

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST. WARD)

2-FULL NAME Leroy Jordan

(a) RESIDENCE NO. St James ST. Md WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer do
(b) General nature of industry, business, or stablishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) Williamsport
(State or country) md

PARENTS

10 NAME OF FATHER Harry Jordan
11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)
12 MAIDEN NAME OF MOTHER Susan Thomas
13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Harry Jordan
(Address) St James md.

15 MAR 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/24 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1924, to March 10, 1924, that I last saw h.. alive on March 10, 1924 and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Leukemia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. James, Md.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical data Findings
(Signed) W. Hoffman, M. D.
, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manor Cem. Md.
DATE OF BURIAL March 12 1924
20 UNDERTAKER Harry H. Wetzke
ADDRESS 1031 W Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84739

CERTIFICATE OF DEATH.

90 D 84739

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Ronner

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	73	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER ? Jacob F. Ronner

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Mont. Rund.

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Municipal Hospital (Address)

15 Filed MAR 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-8, 1921, to 3-11, 1924

that I last saw him alive on 3-10, 1924

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude S. Druce, M. D.

3-11, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 12, 24

20 UNDERTAKER	ADDRESS
Mr. & Mrs. John H. Deufel & Son	801 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 84740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00 D 84740

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1635 N Fulton ST., 19 WARD)

2-FULL NAME Louisa Blahs

(a) RESIDENCE No. 1535 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Blahs

6 DATE OF BIRTH (month, day, and year) Nov 29 43

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Bohnlofinks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henry Hinkler (Address) 1526 N Fulton

15 MAR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9" 1924

17

I HEREBY CERTIFY, That I attended deceased from Feby 7 1924 to March 9 1924,

that I last saw h[illegible] alive on March 9 1924,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Toxic Absorption from Gangrene of left Ankle and foot.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis about (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Duvall, M. D.

3/10, 1924 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	March 11 1924
20 UNDERTAKER	ADDRESS
W M Routzon	2230 N Fulton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84741

HEALTH DEPARTMENT—CITY OF BALTIMORE

84741

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4906 Park Heights St. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda E Timanus

(a) RESIDENCE. NO. 4906 Park Height ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward T Timanus

6 DATE OF BIRTH (month, day, and year) Nov 21 50

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 ~~95~~	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER J T Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nt Known

12 MAIDEN NAME OF MOTHER Nt Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nt Known

14 Informant Campbell Filault

(Address) 4906 Park Heights

MAR 1 1924 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1924

17 I HEREBY CERTIFY, That I attended deceased from March 7th 1924 to March 10 1924

that I last saw her alive on March 10 1924

and that death occurred, on the date stated above, at 4.57 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bubert M. D.

. 19 (Address) 4884 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Mar 13 1924
20 UNDERTAKER H M Routzon	ADDRESS 2230 W Balto

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84742

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 84742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 503 S Curley St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John H Teichman

(a) Residence No. 503 S Curley St., 1 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? 29 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Teichman

6-DATE OF BIRTH (month, day and year) July 18th 1894

7-AGE, 29 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)... auto

(c) Name of employer...

9-BIRTHPLACE (city or town)... City (State or Country),

PARENTS.

10-NAME OF FATHER, Thos Teichman

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise Hordman

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Germany

14- (Informant) Mrs Louise Teichman

(Address) 503 S Curley St

15- FILED MAR 11 1924 Robert P. Harrison, 192... Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 10 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 8, 19 24 to March 10, 19 24

that I last saw h[illegible] alive on March 10, 19 24

and that death occurred, on the date stated above, at 8 9 a. m.

The CAUSE OF DEATH* was as follows:

Edemund Cerebrum

(Duration)... yrs. 2 mos.... ds.

CONTRIBUTORY (Secondary) Unknown. Dupl

(Duration)... yrs.... mos.... ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death?... Date of...

Was there an autopsy?...

What test confirmed diagnosis?...

(Signed) Joseph L. Valentine M. D.

March 11, 1924 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, Mar. 13, 1924

20-UNDERTAKER, Peter Nicolas — ADDRESS 2060 Eastern Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84743 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84743

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Hollins st ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin M Boshell

(a) RESIDENCE No. 1125 Hollins st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1867

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
57	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos Boshell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Elizabeth Schuling wife (Address) 1125 Hollins st

15 Filed MAR 11 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to March 10, 1924.

that I last saw h[illegible] alive on March 10, 1924.

and that death occurred, on the date stated above, at 11.10 a m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

19 (Signed) M. O'Neill, M. D.

3/11, 1924 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 3/1 1924

20 UNDERTAKER George A Farley Fulton st

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

B 84744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

B 84744

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1628 N. Caroline St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sidney A Wolfe

(a) Residence No. 1628 N. Caroline St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Townley R Wolfe

6-DATE OF BIRTH (month, day and year) 4/21/1864

7-AGE. 59 yrs. 10 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Aquilla Leaf

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Co

12-MAIDEN NAME OF MOTHER, Eliza Stanley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Townley Wolfe

(Address) 1632 N. Caroline St

15-

Filed MAR 11 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 10/1924

17- I HEREBY CERTIFY, That I attended deceased from March 5th 24 to March 10 1924

that I last saw her alive on March 9 1924

and that death occurred, on the date stated above, at 8 50 P.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Allen B Freeman M.D.

, 19 (Address) 412 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Highwood Cha Co Md

DATE OF BURIAL, Mar 12 1924

20-UNDERTAKER, John Miller & Co

ADDRESS 1008 Eutaw

Burial Permit Clerk

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84745

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Dillon St. ST., 26 WARD)

2-FULL NAME Mary Herman

(a) RESIDENCE NO. 3407 Dillon St. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sebastian Herman

6 DATE OF BIRTH (month, day, and year) Oct. -1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Herman (Son)

(Address) 3407 Dillon St

15 Filed 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to March 10, 1924, that I last saw her alive on March 9, 1924, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. J. Lohbrechter, M. D.

, 19 (Address) 806 E. 32nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL March 12 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84746

CERTIFICATE OF DEATH.

112 D 84746

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N. Luzerne ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schafer

(a) RESIDENCE NO. 528 N. Luzerne ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/4/1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. D. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mamie Risten, (Address) 528 N Eugene ave

15 Filed MAR 1 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 7th, 1924, to March 10, 1924, that I last saw h[illegible] alive on March 10 1924 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Atonic Senile Dyspepsia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H Rehburger, M. D.

, 19 (Address) 1709 Linn Ann St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Mar 15th 1924
20 UNDERTAKER	ADDRESS
Lilly & Feiler	4038 Wolfe St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84747

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3708 Foster Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emanuel Schindler

(a) RESIDENCE NO. 3708 Foster Ave. ST.: WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schindler

6 DATE OF BIRTH (month, day, and year) March 25-1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brush-maker do
(b) General nature of industry, business, or establishment in which employed (or employer) Pittsburgh Plate Glass Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schindler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wallburga Eff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Schindler
(Address) 3708 Foster ave

15 Filed MAR 11 1924, 192 Robert P. Harrison, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

(Signed) J. Clinton Poole, M. D.
(Coroner)

3/11/24 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar. 15th 1924
20 UNDERTAKER Lilly & Feiler	ADDRESS 403 N. Fremont

MAR 1 1924

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS: AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84748 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 84748

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Hull St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elsie Pietrykowski (Elsie Pulaski) see over

(a) Residence No. 1118 Hull St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sep. 9 1921

7-AGE. 2 yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph . Pietrykowski

11-BIRTHPLACE OF FATHER (city or town)... Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Banach

13-BIRTHPLACE OF MOTHER (city or town)... Poland (State or Country),

14- (Informant)... Mr. Joseph... Pietrykowski

(Address)... 1118 Hull Street

15- Filed... Albert R. Harrison... Registrar.

MAR 1 1924 Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 10/24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 8, 19 24, to Mar. 10, 19 24, that I last saw her alive on Mar. 10, 19 24, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(over)

(Duration)... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)...

(Duration)... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death?... No Date of...

Was there an autopsy?... No

What test confirmed diagnosis?...

(Signed) Wm. T. Seabury, M. D.

3/11, 1924 (Address) 6887 Fait Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Cross A. A. Co.	March 12 1924
20-UNDERTAKER.	**ADDRESS**
John A. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84749

D 84749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wilson

(a) RESIDENCE No. 2065 Fleet ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Archie Wilson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Abt.	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Geo Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Rosie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospital Records.

(Address)

15 Filed ..... 19 Robert P. Harris, Registrar

MAR 11 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-11 1924

17

I HEREBY CERTIFY, That I attended deceased from March 2, 1924, to March 11, 1924,

that I last saw her alive on March 10, 1924,

and that death occurred, on the date stated above, at 12-20 a m.

The CAUSE OF DEATH* was as follows:

Bacteric Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of March 4/24

Was there an autopsy?

What test confirmed diagnosis? Clinical signs

(Signed) [illegible] M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: March 14 1924

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

D 84750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84750

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Mercy Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Priesterjahn

(Residence in Baltimore: No. 204 Spalding Ave St.; 59 yrs. 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Dec 24 1864
(Month) (Day) (Year)

7-AGE. 59 yrs. 2 mos. 15 ds.
If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Standard Sanitary Co

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Theodore Priesterjahn

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Barbara Snyder

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Helen Ringgold
(Address) 204 Spalding Ave

15-
Filed ..... Robert P. Harrison, Registrar.

MAR 11 1924

Burial Permit clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Mch 9 24, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer Throat —
Acute Exhaustion
Klebs Bacil (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia (Duration) ....yrs. ....mos. ....ds.

(Signed) Conway M. D.
(Coroner)
Mch 11 192 4 (Address) 1E 29 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Loudon Park Cem Mar 12 1924

20-UNDERTAKER. Wm Tichner Sons ADDRESS North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84751

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 84751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2809 Elsmore Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. Herr

(a) Residence No. 2809 Elsmore Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie E. Herr

6-DATE OF BIRTH (month, day and year) Feb 12 1876

7-AGE, 48 yrs. mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Bond & Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Geo E Herr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Frances Van Fossen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Jennie E. Herr

(Address) 2809 Elsmore

15- Robert P. Harrison, Registrar.

MAR 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 9/24

17- I HEREBY CERTIFY, That I attended deceased from March 7 1924 to March 9 1924

that I last saw him alive on March 9 1924

and that death occurred, on the date stated above, at 12 30 P M.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Palmer Gorsuch M. D.

3/10/24 (Address) 340 W Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL, Feb 11 1924

20-UNDERTAKER W. G. Richardson — ADDRESS Catonsville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84752

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5342 Denmore Ave ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Mand

(a) RESIDENCE: NO. 5342 Denmore Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 8 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nell Snackmand

6 DATE OF BIRTH (month, day, and year) July 1, 1865

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Jacob Mand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosina Bedgar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Bertie Darnell

(Address) 5342 Denmore Ave

15 Filed MAR 11 1924, 19... Robert P. Harris, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10- 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1923, to 3-10-, 1924

that I last saw h... alive on ..., 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

Prob. 1 yrs. ... mos. ... ds.
(duration)

CONTRIBUTORY (Secondary) Mitral Insufficiency

... (duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C Page, M. D.

, 19 (Address) 1726 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 13 1924

20 UNDERTAKER Martin Fahey & Son

ADDRESS 1837 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84753

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 49 D 84753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE. (NO. 1 ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Mackie

(a) RESIDENCE NO. Sault Ste Maria ST. Ont. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER William Mackie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Kate McPherson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 MAR 12 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 6 , 1924 to Mar 10 , 1924 .

that I last saw h alive on Mar 10 , 1924 ,

and that death occurred, on the date stated above, at 5 20 P m.

The CAUSE OF DEATH* was as follows:

Uremia Malignant Tumor of Kidney (carcinoma)

In Hospital 4 days

(duration) unknown yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Rt. nephrectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/7/24

Was there an autopsy? Yes

What test confirmed diagnosis? nephrectomy

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salt Ste Marie Mich

DATE OF BURIAL March 19 24

20 UNDERTAKER Joseph Ahrens

ADDRESS 224 Derry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17009 84754

86 D 84754

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hosp.

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Lula Long

(a) RESIDENCE NO. 1129 Brentwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
9	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Calvin Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Do Blizzard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) John Hopkins Hosp.

15 MAR 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924, to March 10, 1924, that I last saw her alive on March 10, 1924, and that death occurred, on the date stated above, at 8 45 8 m.

The CAUSE OF DEATH* was as follows:

Acute otitis media

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis & septicemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Mar. 8

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) H. N. Mech, M. D.

. 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL March 13 1924

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Reway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D A K O

Spec.—1-10-21—M&T—1500 Bks.

D 84755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-002
12 D 84755

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 28 Roland Av. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brackett Myers

(a) RESIDENCE NO. 28 Roland Av ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 2 mos. 9 ds. How long in U. S., If of foreign birth? 70 yrs. 2 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Buck Myers

6 DATE OF BIRTH (month, day, and year) Dec- 29-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broker

(b) General nature of Industry, business, or establishment in which employed (or employer) Soap - 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Humphrey Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Catherine Brackett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mr. Miller D. Locke (Son-in-law)

(Address) Baltimore Md.

15 MAR 1 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9: 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1923 to Mar 9: 1924

that I last saw him alive on Mar 9: 1924

and that death occurred, on the date stated above, at 5-50 P m.

The CAUSE OF DEATH* was as follows:

Portal Cirrhosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 13 hrs

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Pearse, M. D.

19 (Address) 205 Church st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar 11 1924

20 UNDERTAKER HART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. Mon...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84756

CERTIFICATE OF DEATH.

74-01 84756

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 311-E-Oakdale ST., 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orlando Bird Bidwell Jr.

(a) RESIDENCE NO. 311-E-Oakdale ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 53 yrs. 7 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leslie Tilden Bidwell

6 DATE OF BIRTH (month, day, and year) Aug-3-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Freeport Illinois

PARENTS

10 NAME OF FATHER O. Bird Bidwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Northampton Massachusetts

12 MAIDEN NAME OF MOTHER Margaret Tompkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northampton Massachusetts

14 Informant Mrs. Leslie T. Bidwell (wife) (Address) 311-E-Oakdale Road.

15 Filed MAR 12 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 10. 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb-28 1924 to March 10 1924, that I last saw h alive on March 10 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

Cerebral Hemorrhage

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 20+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Gatson Parker, M. D.

3/10 1924 (Address) 722 Rutland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Freeport Ill. DATE OF BURIAL Mar 12 1924

20 UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH [illegible]

Wm J. Wilson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84757

CERTIFICATE OF DEATH.

188-003

D 84757

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. J. Wilson

(Residence in Baltimore: No. 922 Lemon st St.; yrs.. mos.....ds.)

WRITE PLAINLY, WITH UNFADING INK. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W Sale

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: Nov (Month) 19 (Day) 1859 (Year)

7-AGE: 64 yrs. 3 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER, Wm Wilson

11-BIRTHPLACE OF FATHER, (State or Country): Va

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wilson

(Address) 922 Lemon st

15-

FILED MAR 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH March (Month) 8 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or ~~inquiry~~.) thereon and from the evidence obtained by said ..... (Inquest, ~~autopsy or inquiry~~.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured Skull

(Duration) ..... yrs. 3 hours mos. ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(Duration) ..... yrs. 1 mos ..... ds.

(Signed) W.R. Forman M. D.

(Coroner.)

3-12, 1924 (Address) 117 W. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: 3/13/24 19....

20-UNDERTAKER: Jno J Gibbs ADDRESS: 220 W Saratoga

Spec.—1-10-21—M&T—1500 Blks.

Frisby

D 84758

HEALTH DEPARTMENT—CITY OF BALTIMORE

21

CERTIFICATE OF DEATH.

D 84758

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Edmondson Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Frisby

(a) RESIDENCE NO. 822 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas. Frisby

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sam Downes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wallace Green

(Address) R. F. D. 2 Newington Ave

15 Filed MAR 7 1924, 19 ROBERT H. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 2d, 1924, to March 8th, 1924, that I last saw h... alive on March 8th, 1924, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza & Tonsilitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Abbott, M. D.

19 (Address) 824 Woodbourne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 [illegible]	DATE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Robt. E. Lee Cem.	3/12 1924

20 UNDERTAKER Samuel A. Hawley ADDRESS 838 Belle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84759

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital 23 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Grant

(a) Residence No. 1003 Creek Alley St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1896

7-AGE.	If LESS than 1 day.
28 yrs. ..... mos. ..... ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

040

9-BIRTHPLACE (city or town) (State or Country) Sandomingo

PARENTS.

10-NAME OF FATHER, Archie Grant

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Sandomingo

12-MAIDEN NAME OF MOTHER, Eliza Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Sandomingo

14-(Informant) Hospital Records

(Address) M.T.H.

15-Filed MAR 12 1924 19... ROBERT R. KRAMER, Assistant Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 6 19 24 to March 8 19 24

that I last saw him alive on March 8 19 24

and that death occurred, on the date stated above, at 5.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray, Sputum.

(Signed) L. A. Lall M. D

3-8-24 19 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	March 11, 1924

20-UNDERTAKER.	ADDRESS
J. E. Brownfield Son	1501 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84760

CERTIFICATE OF DEATH.

90 D 84760

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Jefferson St ST., 5 WARD)

2-FULL NAME Cornelia Jackson

(a) RESIDENCE No 1404 Jefferson St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Edward Jackson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St. Michaels Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) St. Michaels Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary XXXXXXX

13 BIRTHPLACE OF MOTHER (city or town) St. Michaels Md
(State or country)

14 Informant Edward Jackson
(Address) 1404 Jefferson St

15 Filed MAR 1 21924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Collins, M. D.
(Coroner.)

Mar 11/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL Mch 12 1924

20 UNDERTAKER Wm. J. Locks ADDRESS 1302 Jefferson

N.B.—WRITE LEGIBLY, WITH UNFADING INK. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84761

100-09

D 84761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2430 Maryland Ave 17

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Clarke Stevens

(a) RESIDENCE No. 2430 Maryland Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 5 weeks mos. 7 days ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	✓	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Robert Clark Stevens

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Juliett Stevens

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto Md

14 Informant Juliett Stevens
(Address) 2430 Maryland Ave

15 Date MAR 1 2 1924 16 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1924, to March 11, 1924,

that I last saw her alive on March 11, 1924,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Blood of Pneumonia

(Signed) Walter C Bacon, M. D.

3/11, 1924 (Address) 100 E 20

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Mch 13 24

20 UNDERTAKER Mr M Gaulthrop

ADDRESS 2839 Raynor Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84762

CERTIFICATE OF DEATH.

49 D 84762

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Broadway ST., 8 WARD)

2-FULL NAME Albert W Smith

(a) RESIDENCE NO. 1635 Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina. Sis

6 DATE OF BIRTH (month, day, and year) Feb 11, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10 NAME OF FATHER James G Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Martha Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada.

14 Informant Mrs. A. W. Smith
(Address) 1635 N. Broadway

15 Filed MAR 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from 12 a 14 1924, to ..... 19....,
that I last saw him alive on Mch 10. 24 19....,
and that death occurred, on the date stated above, at 3-40 a m.
The CAUSE OF DEATH* was as follows:

Cancer neck

..... (duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) Hypostasis

..... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of abt. 4 mos, xxx

Was there an autopsy? no

What test confirmed diagnosis? cal

(Signed) W. J. Riley M. D.

, 19 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Mar. 12 1924

20 UNDERTAKER C. D. Fanning & Son - 1938 E. Lafayette Ave. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84763

CERTIFICATE OF DEATH.

REGISTERED NO. 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 E 20th St., 9 WARD)

2-FULL NAME Charles R Hartman

(a) RESIDENCE NO. 713 E. 20th St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 17 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	16	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER William Hartman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Alice Pierce

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs Hartman
(Address) 713 E. 20th St

*15 Filed MAR 12 1924 ROBERT R. KRAUTER, Asst. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from March 5 1924, to March 10 1924, that I last saw him alive on March 10 1924, and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows: Malignant Stomatitis

(duration)* yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Neoplasia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) [illegible] M. D.

3/10 1924 (Address) 701 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Mar 12 1924

DATE OF BURIAL

20 UNDERTAKER H. C. Wiedefeld

ADDRESS 114 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Mary A Taylor) ✓

D 84764 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84764

CERTIFICATE OF DEATH. X46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital (Ward) 1

2-FULL NAME Mary A. Taylor

(a) RESIDENCE NO. Ocean City, Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Never 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Taylor

6 DATE OF BIRTH (month, day, and year) July 26, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	53	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Adkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records.

(Address)

15 MAR 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to March 11, 1924

that I last saw her alive on March 11, 1924

and that death occurred, on the date stated above, at 9 45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) Unknown

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) Unknown ds

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of March 11, 1924

Was there an autopsy? no.

What test confirmed diagnosis? Operation ∇

(Signed) Dr. E. N. Blades Laboratory. M. D.

, 19 (Address) 822 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ocean City Md

DATE OF BURIAL Mar 12 1924

20 UNDERTAKER Henry W. Jenkins Sons

ADDRESS McCulloh & Orchard Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84765 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 V D 84765

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 So. Clinton ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANTON T. WIEPRECHT,

(a) RESIDENCE NO. 110 So. Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. ~~XXXX~~ 27 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Wieprecht,

6 DATE OF BIRTH (month, day, and year) February 12-1900.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper,

(b) General nature of Industry, business, or establishment in which employed (or employer) 008

(c) Name of employer Md. Casualty Co.,

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER Charles Wieprecht,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) MD.

12 MAIDEN NAME OF MOTHER Veronika Sitowski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Veronika Wieprecht, (Mother)

(Address) 110 So. Clinton St.

MAR 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10. 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 1 1924 to March 10 1924

that I last saw h[illegible] alive on March 10 1924

and that death occurred, on the date stated above, at 1. P*-- m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Roswell M. D.

19 (Address) March 11th 1801 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, Cem., DATE OF BURIAL Mar. 13" 1924,

20 UNDERTAKER M. F. Sadowski, ADDRESS 905 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84766

CERTIFICATE OF DEATH.

94-002

D 84766

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 N Broadway. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winfield McClintock

(a) RESIDENCE No. 313 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Mary C McClintock

6 DATE OF BIRTH (month, day, and year) Aug 31 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mathew McClintock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Susan Appleby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Cora A McClintock

(Address) 313 N. Broadway

15 Filed MAR 12 1924 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 19.., to Mar 10, 19 24.

that I last saw h.. alive on Mar 10, 19 24,

and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Phy Exam

(Signed) Geo Clinton Bladen, M. D.

3/11/24, 19.. (Address) 1432 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 3-13 1924

20 UNDERTAKER Ehrlich Harle — ADDRESS 115 E Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84767

CERTIFICATE OF DEATH.

74-001

74 D 84767

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3624 Old York Rd. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George H. Matta

(a) Residence No. 3624 Old York Rd St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-~~If married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Anna Matta

6-DATE OF BIRTH (month, day and year) June 15 1861

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Picture Frame Co.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Geo. H. Matta

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Emily V. Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mrs. Cavanaugh

(Address) 3624 Old York Rd

15- Filed MAR 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 1, 1924 to Mar 10, 1924

that I last saw h.. alive on Mar 10, 1924

and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis & hypertension (Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys & Lab

(Signed) M. Leo Stiefel M. D.

3/12, 1924 (Address) 1319 Light St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western

DATE OF BURIAL, 3-13, 1924

20-UNDERTAKER. James Dignan & Son

ADDRESS 1000 E Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84768

CERTIFICATE OF DEATH

31 D 84768

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE: (No.) ST., 16 WARD)

2-FULL NAME Amelia Jeris

(a) RESIDENCE NO. 1503 W. Lafayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Samuel Jeris

6 DATE OF BIRTH (month, day, and year) Unknown 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Boy View Hospital Balto, Md.

15 Filed MAR 12 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6. 1924, to March 11 1924, that I last saw h alive on " 10 1924 and that death occurred, on the date stated above, at 5:00 9. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Psychosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Maryland

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. H. Smith, M. D.

3/11, 1924 (Address) Boy View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL March 1924

20 UNDERTAKER Fortney-Leavens ADDRESS Pratt & Ave

Per H. F. Leavens

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 ✓ D 84769

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ... ST., 76 WARD)

2-FULL NAME Joseph L. Drury

(a) RESIDENCE No. 634 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O'Neill

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Maryland Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Bay View Hospital

(Address) Balto, Md.

15 Filed MAR 12 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1923 to March 11, 1924

that I last saw h[illegible] alive on March 10, 1924

and that death occurred, on the date stated above, at 8:35 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Elsworth M. D.

3/11, 1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 14 1924
18 UNDERTAKER Edward Lenahan & Son	ADDRESS 409 Hollins
Per E. F. Lenahan	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84770 HEALTH DEPARTMENT—CITY OF BALTIMORE 181-001 ✓ D 84770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 115 N Fremont St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Ekel

(Residence in Baltimore: No. 115 N Fremont st — Center St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) Don't Know (Day) ..... (Year) 1.....

7-AGE: 61 about yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bushelman
(b) General nature of industry, business, or establishment in which employed (or employer): 080

9-BIRTHPLACE, (State or Country): N Y,

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Brushafer

13-BIRTHPLACE OF MOTHER, (State or Country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Fahey Sons

(Address) 1318 Light St

15-

MAR 1 21924

192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 8 (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or Inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy~~ or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(Duration) ..... yrs. a few hours mos. ..... ds.

CONTRIBUTORY (Secondary) Accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Forrest M. D. (Coroner.)

3-12 1924 (Address) 117 W. Fayette St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Patricks	3-12-24 19
20-UNDERTAKER,	ADDRESS
J. J. Fahey & Sons	1318 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84771

CERTIFICATE OF DEATH.

74-28

B 84771

1-PLACE OF DEATH

City of BALTIMORE: (No. 601 S. Broadway St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Abraham Goldenberg

(a) Residence No. 601 S. Broadway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Goldenberg

6-DATE OF BIRTH (month, day and year) Oct 1-1857

7-AGE. 66 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

(c) Name of employer.....

9-BIRTHPLACE (City or Town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), R

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), R

14- (Informant) Aaron Goldenberg

(Address) 601 S. Broadway

15- MAR 12 1924 19.. ROBERT E. KRAMER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-12-24

17- I HEREBY CERTIFY, That I attended deceased from Febr 12 1916 to March 11 1924 that I last saw h. in alive on March 10 1924 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
heart failure

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) arteria sclerosis

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) N. Aaron Hellfgott M. D.

3/12, 1924 (Address) 1921 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 3/12 1924
20-UNDERTAKER Jack Levin	ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bertha Schumann

D 84772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84772

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2736 W Fairmount Av St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Schuman

(a) RESIDENCE. No. 2736 W Fairmount Av St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? 13 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elsa Schumann

6 DATE OF BIRTH (month, day, and year) Oct 28 1890

7 AGE: Years 33; Months 4; Days 13; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 030

(c) Name of employer: Gurney

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Wilhelm Schuman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Agnes Probst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Agnes Buschman

(Address) 1162 - 41st St.

15 Filed MAR 12 1924 ROBERT N. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 3 1924, to Nov 11, 1924, that I last saw h alive on Nov 11, 1924, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hamon Kalyn M. D.

3/12, 1924 (Address) 202 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: March 15 1924

20 UNDERTAKER: C. W. Dill

ADDRESS 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 84773

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-002 ✓

D 84773

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave St.; 21 WARD)

2-FULL NAME John C Davis

(Residence in Baltimore: No. Home for the Aged of the M.E Church St.; 54 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, January 10, 1839
(Month) (Day) (Year)

7-AGE, 85 yrs. 2 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jonathan Davis

11-BIRTHPLACE OF FATHER (State or Country) Massachusetts

12-MAIDEN NAME OF MOTHER Mary Kimmy

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cassady

(Address) 400 N. Fulton Ave

15-

MAR 12 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6th 1924, to March 11 1924, that I saw him alive on Mch 9 1924, and that death occurred, on the date stated above, at 8-45 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

(Duration) 3 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation Acute

(Duration) 2 yrs. 5 mos. 5 ds.

(Signed) George C. Shannon M. D.

3/11, 1924 (Address) 702 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet

DATE OF BURIAL, March 13 1924

20-UNDERTAKER George J. Smith

ADDRESS 1532 Hollins st

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84774

CERTIFICATE OF DEATH.

X 129 ✓ D 84774

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E Virginia Ave St.; 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lula May Hubbard

(Residence in Baltimore: No. 2 months at 117 E Virginia Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ...April (Month) 12 (Day) 1857 (Year)

7-AGE,	If LESS than 1 day,
36 yrs. 11 mos. ....ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harrison G Woolford

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Amelia Steinbock

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harrison G Woolford

(Address) 117 E Virginia Ave

15- MAR 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 17 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 9 1924, to March 17 1924, that I saw her alive on March 11- 1924, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Chronic

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) from history Myocarditis

(Duration) 9 ✓ yrs. 6 mos. ✓ ds.

(Signed) Geo. C. Shannon M. D.

March 17, 1924 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Taylors Island Md

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Loudon Park Cem	3/19/1924
20-UNDERTAKER	**ADDRESS**
Guy Smith 1332	Hollins st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84775

CERTIFICATE OF DEATH.

5 179

D 84775

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Mc Elderry ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna J. Baker

(Residence in Baltimore: No. 1408 Mc Elderry St.; 15 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE, B.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, April (Month) 10 (Day), 1879 (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 670

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Alexander Brookes

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Fannie Pearce

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. A. Elliott

(Address) 1725 Carlland ave.

Filed MAR 12 1924, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 8 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feby 29 1924, to March 8 1924, that I saw her alive on March 1924, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Abs Pneumonia mastoiditis

Influenza

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Hornstein M. D.

3/13, 1924 (Address) 733 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Mar 12 1924

20-UNDERTAKER Mrs R. A. Elliott — ADDRESS 1725 Carlland ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 001 ✓ D 84776

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 Smith Ave, Dorchester St. 25 Heights Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Josephine Eckman

(a) Residence No. 9 Smith Ave, Dorchester Heights Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 11, 1924

7-AGE.	If LESS than 1 day.
0 yrs. 0 mos. 0 ds.	hrs. or 3 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER. John Eckman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER. Jeanette Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) John Eckman

(Address) 9 Smith Ave Dorchester Hts

15- Filed MAR 12 1924 Notary PJ Harrison, Registrar.

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 11 1924 to March 11 1924 that I last saw her alive on March 11 1924 and that death occurred, on the date stated above, at 10.34 a.m.

The CAUSE OF DEATH* was as follows:

Pernalous Colitis.

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Raymond T. Thum M. D

1924 (Address) 1 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	Mar. 13, 1924
20-UNDERTAKER.	ADDRESS
Nelson E. Stiles	320 Md. Ave Westport, Md

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84777

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Smith Ave, Dorchester St. Heights (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eckman

(a) RESIDENCE. No. Smith Ave., Dorchester St. Heights WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 8 min.
	0	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Eckman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Jeanette Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John Eckman
(Address) Dorchester Heights

15 Filed . 19 Robert P. Harrison, Registrar

MAR 1 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to March 11, 1924, that I last saw her alive on March 6, 1924, and that death occurred, on the date stated above, at 6 00 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bulbar.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus Bulbar

(Signed) Raymond Gilmour M. D.

1924 (Address) Oakland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar 13 1924

20 UNDERTAKER Nelson E. Stiles — ADDRESS 320 Md. Ave Westport.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84778

CERTIFICATE OF DEATH.

113

D 84778

1-PLACE OF DEATH St Vincent Infant Hosp

CITY OF BALTIMORE: (No. 1401 Division St ST.: ..... WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Harold Lloyd.

(Residence in Baltimore: No. 1401 Division St St Vincent Infant Hospital St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Aug 29, (Month) (Day) 1923. (Year)

7-AGE. ..... yrs. 6 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Ethel Shirey

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St Vincent Infant Hosp

(Address) 1401 Division

15- Filed ..... 191.....

Robert P. Harris, Registrar.

MAR 1 2 1924

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 11 1924, to March 17 1924, that I saw him alive on March 17 1924, and that death occurred, on the date stated above, at 4.35 A m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis acute

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jacob Fisher M. D.

3/12/24, 191... (Address) 1823 N. Wash Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral

DATE OF BURIAL. March 19 191...

20-UNDERTAKER Martin Bakey & Co

ADDRESS 1621 W North Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 84779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3305 Marshall ct. ST., 26 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel E. McC. Elwers

(a) RESIDENCE NO. 3305 Marshall ct. ST., 26 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McC. Elwers.

6 DATE OF BIRTH (month, day, and year) March 29-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) General Utility man

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William McC. Elwers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Cavens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary McC. Elwers
(Address) 3305 Marshall ct.

15 Filed MAR 12 1924 Robert P. Harrison, Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 11, 1924 that I last saw him alive on March 11 - 24 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(duration) X yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Brights disease

(duration) / yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

(Signed) Jas L. Truax, M. D.

(Address) 2485 E 31st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL March 13 1924

20 UNDERTAKER Lilly & Zile

ADDRESS 403 S Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84780

1-PLACE OF DEATH Johns Hopkins Hospital. REGISTERED NO. 161

CITY OF BALTIMORE: (No. 7 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Adams

(a) RESIDENCE NO. 520 N Rose ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital. (Address) JOHNS

Filed MAR 7 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1924

17

I HEREBY CERTIFY, That I attended deceased from March 5, 19 24 to March 7, 19 24

that I last saw him alive on March 7, 19 24

and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E E Duncan, M. D.

3/7, 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner of Health.

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84781

D 84781

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Spotten

(a) RESIDENCE NO. 1512 E Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Spotten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Annie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital.

15 Filed FEB 27 1924, 19 Robert P. Harrison, Registrar

1527

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 22, 1924, to Feb 24, 1924, that I last saw him alive on Feb 24, 1924, and that death occurred, on the date stated above, at 10 00 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Edmunson, M. D.

2/27 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

JOHNS HOPKINS HOSPITAL MAR 11 1924

20 UNDERTAKER — ADDRESS

Commissioner of Health.

PERMIT ISSUED

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84782

84782

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 943 Ensor St ST. 10 WARD)

2-FULL NAME Rapheal Guidice

(a) RESIDENCE No 943 Ensor St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Boncetta Guidice

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Musician
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.Marines
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Leberata Giudice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Capo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. Annata Carbone
(Address) 943 Ensor St

15 FILED MAR 21 1924 192 Edward F. Harnish Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Apoplexy (Hemorrhage)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) ....., M. D.

Mar 12/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elmer W Conklin 924	Eager 192
20 UNDERTAKER	ADDRESS
I Holy Redeemer Cem	3/10/24

If LESS than 1 day, the exact statement of hours or minutes should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE that it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84783 — 60-001 — D 84783

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Genl Hospl ST., (or WARD) (If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie Shipley.

(a) RESIDENCE NO. Jessup Md. ST., WARD Jessup Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Shipley

6 DATE OF BIRTH (month, day, and year): September 1880

7 AGE: Years 43 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER: Winfield Dempsey
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Haines
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Wm. Shipley Jessups Md.

15 . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3 - 11 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-28, 1924, to 3-11, 1924, that I last saw her alive on 3-11, 1924, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Complication

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia - Cardiac Insufficiency (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Stonebraker, M. D.

. 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Popular Springs, Md. | DATE OF BURIAL: Mar. 13 1924

20 UNDERTAKER: Jno R. Weer | ADDRESS: Sykesville

MAR 12 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S OR OCCUPANT'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84784

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84784

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 S. Robinson ST.: 1st WARD)

2-FULL NAME Jacob Schissler

(a) RESIDENCE. NO. 1113 S. Robinson ST., 1st WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Jane Schissler

6 DATE OF BIRTH (month, day, and year) Feb 6 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	-1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of Industry, business, or establishment in which employed (or employer) Ship yard

(c) Name of employer Baltimore Steel Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George J. Schissler

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER not remembered

13 BIRTHPLACE OF MOTHER (city or town) ——
(State or country) Germany

14 Informant Frank Schissler
(Address) 1107 S. Kenwood Ave.

15 Filed MAR 12 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924, to March 9, 1924

that I last saw him alive on March 8, 1924,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) —yrs. —mos. —ds.

CONTRIBUTORY (Secondary) Sub acute gastritis

(duration) ...yrs. ...mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

3/12, 1924 (Address) 1014 S. Ellwood Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	March 13 1924
20 UNDERTAKER	ADDRESS
Williamback	502 E North Ave

I. B.—WRITE PLAINLY, WITH UNFADING INK—
mation should be carefully supplied. AGE sho
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hosp 16 St. ..... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.. Fannie R. Gaither

(a) Residence No. 1904 W Mosher St., ... Ward .....
(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Harry F Gaither

6-DATE OF BIRTH (month, day and year) Nov 13 1858

7-AGE. 65 yrs. 3 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town). (State or Country). Md.

PARENTS.

10-NAME OF FATHER Wm. H Brann

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Eliza Spencer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Harry Gaither

(Address) 1904 W. Mosher

15- Filed MAR 1 2 1924 16- Robert P. Harris, Registrar.

Dr. Glassman 7431 W Market Place East

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 11-24

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 24 to 24. to Mar 11 1924 that I last saw h.. alive on Mar 11 to 24 and that death occurred, on the date stated above, at 12.30 p.m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Independent (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tubercular Toxemia

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Harry Glassman M. D.

Mar 12 1924 (Address) 2687 Wrenken Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sand Mt. Cemetery DATE OF BURIAL. Mar 15 1924

20-UNDERTAKER, William Lack ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84786

CERTIFICATE OF DEATH.

74-89 D 84786

1-PLACE OF DEATH Holliday Street between

CITY OF BALTIMORE: (No. Baltimore & Fayette Streets ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold Phillips.

(a) RESIDENCE NO 104 West 25th Street ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Johanna M. Phillips

6 DATE OF BIRTH (month, day, and year) August 5, 1868.

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs or ....min
	55	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer) Curtis Brothers
(c) Name of employer Philadelphia

9 BIRTHPLACE (city or town) (State or country) Madison Wisconsin

PARENTS

10 NAME OF FATHER Frederick Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Madison Wisconsin.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Johanna Phillips (wife)
(Address) 104 West 25th, Street

15 Filed ..... 192 Robert P. Harrison, Registrar

MAR 12 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

Signed Otto K. Bonnaudt, M. D. (Coroner.)

March 12 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL March 13 192 4

20 UNDERTAKER Wm Cook — ADDRESS 502 East North Ave.

...BE should be stated EXACTLY. PHYSICIAN should state it may be properly classified. Exact statement of OC... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on b... on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84787

CERTIFICATE OF DEATH.

2 ✓ D 84787

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 1 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Moore

(a) Residence No. 2308 E. Fleet St., Ward.....

(Usual place of abode)

(If non resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Moore

6-DATE OF BIRTH (month, day and year): 1855

7-AGE: 69 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS:

10-NAME OF FATHER: John Imber

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Municipal Hospital

(Address)

MAR 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-10-24

15. I HEREBY CERTIFY, That I attended deceased from 3-5 1924 to 3-10 1924

that I last saw h[illegible] alive on 3-10 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Fatal Empyema

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronco-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Burns M. D

3/12 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	March 13, 1924
20-UNDERTAKER	ADDRESS
H. Sander Sons	1710 East H

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84788

CERTIFICATE OF DEATH.

3/ D 84788

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Gouhg St. St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Shutt

(a) RESIDENCE NO. 1809 Gouhg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1877,

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrition 079

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER James Shutt

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margt. Shilling

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Miss. Matilda Wolsch
(Address) 1809 Gough St.

15 Filed MAR 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1924, to March 10, 1924, that I last saw him alive on Mar 9, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis Phy Exam

(Signed) Geo Clinton Shadel, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mch. 13, 1924
20 UNDERTAKER	**ADDRESS**
Wm. C. Black,	927 N. Broadway,

D 84789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X185 D 84789

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin General Hospital 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thomas Werner Tranberg

(Residence in Baltimore: No. 324 E Baltimore St St.; yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Mal	white	Married

6-DATE OF BIRTH, dec (Month) 28 (Day) 1879 (Year)

7-AGE, 44 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Journeyman

9-BIRTHPLACE, (State or Country), Norway

PARENTS.

10-NAME OF FATHER, Haakon Tranberg

11-BIRTHPLACE OF FATHER, (State or Country), Norway

12-MAIDEN NAME OF MOTHER, Marie Werner

13-BIRTHPLACE OF MOTHER, (State or Country), Norway

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olga Tranberg

(Address) 3024 E Balt St

15-

MAR 13 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 11 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture L. femur by fall while at work (accidental) (Communited) (ours)

(Duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Kerbin M. D. (Coroner.)

Mar 12 1924 (Address) 707 Cleve

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place of death ....yrs. ....mos. 15 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Frederick Harbor Hos

Former or usual residence 3024 E Balt St

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, 3/14 1924

20-UNDERTAKER, J. A. Moran — ADDRESS 3096 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 84790

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2811 E. Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Margaret S. Hoover

(a) Residence No. 2811 E. Monument St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug. 8 1923

7-AGE, ...yrs. 7 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Frank Hoover

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Margaret E. Fisher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14- (Informant) Frank Hoover

(Address) 2811 E. Monument St.

15- MAR 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mch 11 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 24, 19 24, to Mch 11, 19 24, that I last saw h.. alive on Mch 11, 19 24, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Abram B Lennard, M. D.

3/13, 1924 (Address) 718 N Pat Pkwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Westlawn Memorial Gardens

DATE OF BURIAL, Mar. 13th 1924

20-UNDERTAKER, J. A. Moran

ADDRESS 3000 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84791

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2209 Elsinor Ave ST.) 15 (WARD) 74001 REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Bump

(Residence in Baltimore: No. 2209 Elsinor Ave St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec. (Month) 29 (Day), 1852 (Year)

7-AGE. 72 yrs. 2 mos. 11 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Christofer Schott

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Brauer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George C. Bump

(Address) Laurel Md.

MAR 13 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 11 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....da.

(Signed) [illegible] M. D.
(Coroner.)

March 12, 1924 (Address) 32 32 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, March 13, 1924

20-UNDERTAKER Josiah Bryan & Co — ADDRESS 201 N Martin Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 84792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Bevan ST., 22 WARD)

2-FULL NAME Waller Allen

(a) RESIDENCE NO. 725 Bevan ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Contractors

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Squire Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Florence Jackson Aunt

(Address) 725 Bevan St.

15 MAR 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/1924

17

I HEREBY CERTIFY, That I attended deceased from 3/7/24, to 3/10/24.

that I last saw him alive on 3/10/24,

and that death occurred, on the date stated above, at 6.05 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

duration yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

duration yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Lumpkin, M. D.

3/11/24 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL 3-13 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84793

CERTIFICATE OF DEATH.

3 | D 84793

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 504 W. Lee ST. 22 WARD)

2-FULL NAME Florence Midget

(a) RESIDENCE NO. 504 W. Lee ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Midget

6 DATE OF BIRTH (month, day, and year) Sept 26 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Foster

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Montgomery

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Eliza Foster
(Address) 504 W. Lee

15 MAR 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/1924

17 I HEREBY CERTIFY, That I attended deceased from 2/27/1924, to 3/10/1924, that I last saw h[er] alive on 3/9/1924, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tb.

duration 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

Recurrent duration about 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gunby Bowley, M. D.

3/12/1924 (Address) 908 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3-13 1924

20 UNDERTAKER Jno. H. Toadvine — ADDRESS 142 Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84794

CERTIFICATE OF DEATH.

100-001

D 84794

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 232 N Durham ST., 7 WARD)

2-FULL NAME Mary Johnson

(a) RESIDENCE No. 232 N Durham ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Mr. R. Taylor
(Address) 524 Reliance St

15 Filed ..... 192 ROBERT R. KRAUTER, Register
MAR 1 3 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) ... yrs. ... mos. 7 ds.

(Signed) William Blodt, M. D.

3/13/24, 192 (Coroner.) (Address) 1446 Mt Pleasant Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 3-15 1924

20 UNDERTAKER Paul Taylor

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

1916 43

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84795

D 84795

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ... St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Carter

(a) RESIDENCE No. 14 Kinship Rd Dundalk

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 1 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	X	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Walter Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Woldge Wilkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924, to March 11, 1924.

that I last saw her alive on March 11, 1924

and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) 0 yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? Dundalk, Md.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P. M.

(Signed) Charles H Peckham, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md — DATE OF BURIAL: Mar 13 1924

20 UNDERTAKER: J F Denny — ADDRESS: 715 Lights St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84796

CERTIFICATE OF DEATH.

X 49 ✓ D 84796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home - Infirmary

CITY OF BALTIMORE: (No. N. Baltimore ST. 19 WARD)

2-FULL NAME Mary Elizabeth Lucas

(a) RESIDENCE NO. 1401 W. Fayette ST., WARD New Jersey

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 14 1856

7 AGE: Years 68 — Months — Days 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): 048

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: Richard Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Frances A. Fraston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant: Sophie H. Bell

(Address) 1401 W. Fayette St

15 MAR 13 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to Mar 12, 1924,

that I last saw h[illegible] alive on Mar 12, 1924,

and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) yrs. 3 mos. + ds.

CONTRIBUTORY (Secondary) Hydrothorax

(duration) yrs. 3 mos. + ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? YES Date of Dec 28. 24.

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray, Observation

(Signed) Cayetano Paunetto, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa — DATE OF BURIAL: Mch 14 1924

20 UNDERTAKER: John A. Mitchell — ADDRESS: 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 84797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

137 D 84797

REGISTERED NO.

1-PLACE OF DEATH Frank Cin Sq Hospital

CITY OF BALTIMORE: (No. 1127 Montpelier ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie L. Huthman

(a) RESIDENCE No. 1127 Montpelier ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis X. Huthman

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fred A. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER E. J. Danner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frances X. Huthman

(Address) 1127 Montpelier St

15 MAR 13 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1924

17

I HEREBY CERTIFY, That I attended deceased from March 6 1924 to March 12 1924

that I last saw her alive on March 12 1924

and that death occurred, on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

Dermatomyositis - Renal insufficiency accidental

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of March 6/1924

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Physical

(Signed) F. H. Thomas, M. D.

March 13, 1924 (Address) 1228 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 15 1924
20 UNDERTAKER	ADDRESS
Geo. M. Zinck & Son	811 N. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84798

CERTIFICATE OF DEATH.

D 84798

1-PLACE OF DEATH

City of BALTIMORE: (No. 747 E. 30th St., 9 Ward) Registered No. 129

2-FULL NAME Dora Getterman

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 747 E. 30th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Geo. L. Getterman

6-DATE OF BIRTH (month, day and year): July 30th 1873

7-AGE: 50 yrs. 7 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Heinrich Klever

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Wilhelmina Poltrock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Geo. L. Getterman

(Address): 747 E. 30th St.

15-

Filed MAR 13 1924 16- ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 10th 1924

I HEREBY CERTIFY, That I attended deceased from Jan. 18 1924 to March 10 1924

that I last saw her alive on March 10 1924

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Convalescent Nephritis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. L. Getterman M. D.

3/11/24 (Address) 403 S. 25th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: March 13th 1924

20-UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St.

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be carefully supplied. OCCUPATION should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1700 25 D 84799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84799

1-PLACE OF DEATH CITY OF BALTIMORE: (No.) John Hopkins Hosp. ST., 7 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarissa Jackson

(a) RESIDENCE NO. 5212 Belmore Ave (Usual place of abode) Roslyn Md.

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Dec 12 1922

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Eunice Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky

12 MAIDEN NAME OF MOTHER: Marie Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records John Hopkins Hosp. (Address)

15

MAR 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1924, to March 11, 1924, that I last saw he alive on March 11, 1924, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Congenital syphilis (duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Wassermann

(Signed) H. H. Weech M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Chapel

DATE OF BURIAL: 3/12 1924

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 928 N Bethel

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

41

D 84800

CERTIFICATE OF DEATH.

D 84800

1-PLACE OF DEATH University Hospital Baltimore REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Collins

(a) RESIDENCE NO. 3438 Seneca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write which): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 14 1862

7 AGE: Years 62 Months Days 25 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Bosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: H Tracey (Address) 3438 Seneca St

15 Filed MAR 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 10th 1924 to Mar 11th 1924.

that I last saw her alive on Mar 11th 1924

and that death occurred, on the date stated above, at 10.22 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma ovis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John M. Edmonds, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: March 14 1924

20 UNDERTAKER: CHENOWETH & SON, — ADDRESS: 3517 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84801

CERTIFICATE OF DEATH

D 84801

1-PLACE OF DEATH (a) St. Agnes Hospital 12 29 Registered No.

City of BALTIMORE, (No.) St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Stinefelt

(a) Residence No 1516 Baldwin St. City Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE W.

5-~~Single~~ Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred Stinefelt

6-DATE OF BIRTH (month, day and year) Dec 8 1894

7-AGE 29 yrs mos ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER Robt Strickler

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Do not know

14-Informant Mrs. M. Stinefelt

(Address) 1516 Baldwin St

15-Filed MAR 13 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 12-1924

17-I HEREBY CERTIFY, That I attended deceased from March 11 1924 to March 12 1924

that I last saw h[e] alive on March 12 1924

and that death occurred on the date stated above, at 4-20 A m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis

Hypertension

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis chronic

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) S. Goldman M. D

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or if deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Hampden	March 15-1924

20-UNDERTAKER ADDRESS

CHENOWETH & SON, 3617 CHESTNUT AVE.

R. S.—WRITE PLAINLY. INK should be used. All items should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 D 84802

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2429 Callow ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harris. Sr. Brodel

(a) Residence No. 2429 Callow ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Leah Brodel

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Hebrew Teacher

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Mendes Brodel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis (Address) 1439 E Balto

15- MAR 13 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/12/24

17- I HEREBY CERTIFY, That I attended deceased from Sept. 14 1923 to March 12 1924

that I last saw h.. alive on March 12 1924

and that death occurred, on the date stated above at 3A m.

The CAUSE OF DEATH* was as follows:

Malignant Tumor of the Lung (Left)

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Samuel Wolinsky M. D.

3/12 1924 (Address) 2444 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Hebrew Cem DATE OF BURIAL. 3/13 1924

20-UNDERTAKER. Jack Levis ADDRESS 439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84803 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84803

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 Ensor St., 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hayes

(a) Residence No. 1509 Ensor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Hayes

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Edward J. Hayes

(Address) 1509 Ensor St.

15- MAR 13 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 10/24

17- I HEREBY CERTIFY, That I attended deceased from 2/19 1924 to 3/10 1924 that I last saw h er alive on 3/10 1924 and that death occurred, on the date stated above, at 2 m. The CAUSE OF DEATH* was as follows:

Senility.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. H. Bernardou, M. D.

3/11, 1924 (Address) 914 E. Biddle St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Peters Cemetery	March 14 1924
20-UNDERTAKER.	ADDRESS
Chas. E. Evans & Son	1180 W. Royal Ave

N. B.—WHITE CARDS, Male; PINK, Female. CAUSE OF DEATH should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84804

CERTIFICATE OF DEATH.

90

D 84804

1-PLACE OF DEATH 1503 N. Mulberry St

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucretia Anderson

(a) RESIDENCE NO. 1503 N. Mulberry St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of Late John M. Anderson

6 DATE OF BIRTH (month, day, and year) June 21-1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	8	19.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward W. Ruark

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Ann Ringgold

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Elizabeth S. Ruark.
(Address) 2736 Baretts Ave

15 Filed MAR 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 11, 1924, that I last saw h[illegible] alive on March 10, 1924, and that death occurred, on the date stated above, at 12,15 9 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. O'Neill M. D.

3/12/24, 19 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet cemetery	Mar 13 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84805

HEALTH DEPARTMENT—CITY OF BALTIMORE

450 D 84805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2017 Harlem Ave.

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Norris

(a) RESIDENCE NO. 2017 Harlem Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lucretia Norris

6 DATE OF BIRTH (month, day, and year) Feb 5. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Norris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Monsett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Lucretia Norris.
(Address) 2017 Harlem Ave

MAR 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to March 9, 1924, that I last saw him alive on March 9, 1924, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:
Primary Adenocarcinoma
Caused by Cancer of Colon & Rectum
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? Abdominal Perineal
Was there an autopsy? .....
What test confirmed diagnosis? Microscopic
(Signed) Conrad A. Morgan, M. D.
, 19 (Address) 1322 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edward Chapel Annapolis Md — DATE OF BURIAL: Mar 14 1924

20 UNDERTAKER: Henry H. Witzke — ADDRESS: 1531 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84806

1-PLACE OF DEATH

City of BALTIMORE: (No. 14 Wisteria Ave Hamilton St., 27 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... William Franz .....

(a) Residence No. 14 Wisteria Ave St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Late Catherine Franz

6-DATE OF BIRTH (month, day and year) Aug 7/50

7-AGE, ... 73 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired 034

(b) General nature of industry, business, or establishment in which employed (or employer)..... Grocerer,

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) John Franz

(Address) 14 Wisteria Ave

15-

MAR 13 1924

16- ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 10/24

I HEREBY CERTIFY, That I attended deceased from March 9 19 24 to March 10 19 24

that I last saw him alive on March 10 19 24

and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Morris B. Green M. D

3/11 1924 (Address) Hamilton Baltimore Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore — DATE OF BURIAL, 3/13, 1924

20-UNDERTAKER, Philip Henry — ADDRESS 2016 Orleans St.

All the blanks should be carefully filled. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84807

CERTIFICATE OF DEATH.

90 ✓ D 84807

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 S. Payson Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHANA FRIEDMAN

(a) Residence No. 605 S. Payson Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sholom Friedman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER, Levy Kandell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Gittel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Balto St

15- ROBERT R. KRAUTER, Registrar.

MAR 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13-24

17- I HEREBY CERTIFY, That I attended deceased from April 21 1915 to March 13 1924 that I last saw her alive on March 12 1924 and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration): 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Peck M. D.

3/13. 1924 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Rodeph Shalom	3-13 1924
20-UNDERTAKER,	ADDRESS
Jack Lewis	1439 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84808

CERTIFICATE OF DEATH.

17 D 84808

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Division ST., 14 WARD)

2-FULL NAME Alice Howard

(a) RESIDENCE NO. 1408 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Diggs

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lankman.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lankman.

14 Informant Chas. Garrett
(Address) 1408 Division

15 Filed 192 ROBERT R. KRAUTER, Registrar
MAR 13 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(duration) 2 yrs. mos. ds.

(Signed) J. E. T. Hennessy, M. D.
(Coroner.)

March 10, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedony Cemetery — DATE OF BURIAL: Mar 13 1924

20 UNDERTAKER: Mrs. R. G. Ellick — ADDRESS: 1725 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84809

CERTIFICATE OF DEATH.

101-00 D 84809

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 E 27th St. (ST.) 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Herron Hanna

(a) RESIDENCE NO. 526 E. 27th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan A Hanna

6 DATE OF BIRTH (month, day, and year) March 3rd 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 016

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Railway.

9 BIRTHPLACE (city or town) (State or country) Bayonne New Jersey.

PARENTS

10 NAME OF FATHER Robert H. Hanna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey.

14 Informant (Address) Wm. Hanna 526 E 27th St.

15 MAR 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 29th, 1924, to March 12th, 1924, that I last saw h— alive on March 11th, 1924, and that death occurred, on the date stated above, at 5.00 o'clock P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jas W Thompson M.D. M. D.

3/13/24 (Address) 4012 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem DATE OF BURIAL March 14 1924

20 UNDERTAKER E A Weisfeld Jr ADDRESS 501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84810

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

2-FULL NAME James N. Delaney

(a) RESIDENCE NO. 3951 Falls Road ST., 13 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Mary James Delaney Lida B. Delaney

6 DATE OF BIRTH (month, day, and year) Aug. 29-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 15

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Tom. Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

MAR 1 3 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 8, 1924, to Mar. 10, 1924, that I last saw h alive on Mar. 10, 1924, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Sudden death - unexplained

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Market, Balto Co. Md. DATE OF BURIAL March 14, 1924

20 UNDERTAKER Horace G. Burgee ADDRESS 631 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84811

99-002

D 84811

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3050 Abell Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wilhelmina Todd

(a) Residence No. 3050 Abell Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John H Todd

6-DATE OF BIRTH (month, day and year) Nov 23 1849

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm H Elliott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary L Holland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Jacob Detaken

(Address) 3050 Abell Ave

15-

Filed MAR 13 1924 ROBERT R. KRAUSER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 12 1924

17- I HEREBY CERTIFY, That I attended deceased from March 12 1924 to March 12 1924 that I last saw her alive on March 12 1924 and that death occurred, on the date stated above, at 3-40 P. m. The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

About 5 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Stewart M. D.

3-13-24 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, March 14, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84812

CERTIFICATE OF DEATH.

90 D 84812

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1620 E. Preston St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maria E. Schaefer

(a) Residence No. 1620 E. Preston St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John H. C. Schaefer

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 96 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Nun

(b) General nature of industry, business, or establishment in which employed (or employer). RRR

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-

(Informant) Maria Schaefer

(Address) 120 Asquith St

MAR 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 11, 1924

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1924 to Mar 11, 1924

that I last saw h.. alive on Mar 14 1924

and that death occurred, on the date stated above, at 6-30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Capt. J. Green M. D.

3-11, 1924 (Address) 120 Asquith St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem

DATE OF BURIAL. Mar 14, 1924

20-UNDERTAKER, John Ulrich

ADDRESS E. Preston

N. B.—NAME PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Cause of death should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84813

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. No 2. Rose place ST.: 11 WARD)

2-FULL NAME Robert Harper -

(a) RESIDENCE. No. No 2. Rose place ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs — mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edw Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Harriet Vincent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Edw Harper
(Address) No 2 Rose Place

15 MAR 13 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch 11— 1924, to Mch 12th, 1924, that I last saw him alive on Mch 12th— 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination of Chest

(Signed) Samuel A. David, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-13 1924
20 UNDERTAKER	ADDRESS 916
David Easton	Penna Ave

Burial Permit Clerk.

E.—WRITE PLAINLY, with UNFADING INK—THIS IS A LEGAL DOCUMENT. All questions should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should be stated in every case. Exact statement CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCU TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84814

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

2-FULL NAME George Riley

(a) RESIDENCE NO. 226 S Caroline ST. ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE — Years: 61 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lock-smith

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Municipal Hospital Reeds

15 MAR 13 1924 19 Robert P. Harries Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 3 - 10 19 24

17 I HEREBY CERTIFY, That I attended deceased from 11 - 24 1923 to 3 - 10 19 24 that I last saw him alive on 3 - 10, 19 24 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Myocarditis
Myocardial degeneration

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Gob.

(Signed) Claude S. Deane, M. D.

3-11 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND
Commissioner of Health,
MAR 13 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-001 ✓ D 84815

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hennemore

(a) Residence No. 1149 N. Fremont St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of Industry business, or establishment in which employed (or employer)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Daniel Garrett

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penn

12-MAIDEN NAME OF MOTHER. Delphia Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Municipal Hospital Record

(Address).....

15- Filed MAR 13 1924 Robert P. Harrison, Registrar. Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-3-24

17- I HEREBY CERTIFY, That I attended deceased from 2-29 1924 to 3-3 1924 that I last saw h.. alive on 3-3 1924 and that death occurred on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death*

Did an operation precede death*. No Date of

Was there an autopsy*. Yes

What test confirmed diagnosis*. Autopsy

(Signed). Claude D. Brown M. D

3-4 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ... 19....

20-UNDERTAKER ADDRESS

MAR 18 1924

1283

UNIVERSITY OF MARYLAND

Medical Certificate of Death

MAR 18 1924

WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 V

D 84816

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Poulson

(a) Residence No. 22 S. Spring St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) ?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ?

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), ?

PARENTS.

10-NAME OF FATHER. ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital

(Address) UNIVERSITY OF MARYLAND

15- Filed ..... 192.. Registrar.

Filed MAR 13 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-10-24

17- I HEREBY CERTIFY, That I attended deceased from 3-5- 192X to 3-10- 192X

that I last saw h.. alive on 3-10- 192X

and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) Claude 9 Horan M. D.

3-13- 192X (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS MAR 13 1924

UNIVERSITY OF MARYLAND

Commissioner Health.

1-35

WRITE PLAINLY, with pen and ink—and DO NOT FOLD. Fill in ALL blanks. Data must be entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84817

HEALTH DEPARTMENT—CITY OF BALTIMORE

W 84817

100-60

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3717 Eastern Place ST., 26 WARD)

2-FULL NAME Jos S. Martin

(a) RESIDENCE No. 3717 Eastern Pl- ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John S. Martin

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Ethel M. Mauler

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant John M. Martin
(Address) 3717 Eastern Ple

15 Filed MAR 13 1924, 192 Robert P. Harris Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap. Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo Clinton Black, M. D.

(Coroner)

3/13/24, 192 (Address) 145 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehnorth's

DATE OF BURIAL March 14th 1924

20 UNDERTAKER Lilly & Zitzer

ADDRESS 405 E Wolfe

Burial Permit Clerk

MAGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84818

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.) 5000 Denmore Ave (St.) (Ward) 27

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Rice

(a) Residence No. 5000 Denmore St Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write one word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Chas N. Rice

6-DATE OF BIRTH (month, day and year): Nov 1 1864

7-AGE: 59 yrs. 4 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Geo K. Stump

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Mr Chas N Rice

(Address) 5000 Denmore Ave

15- Robert P. Harris, Registrar.

Filed ..... 192.....

Burial Permit Clerk.

MAR 13 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 19 24 to March 11 19 24

that I last saw h. alive on March 10 19 24

and that death occurred, on the date stated above, at 8.12 M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

To my knowledge (Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Asthenia (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McCleary M. D

, 19 (Address) 1609 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem — DATE OF BURIAL: Mar 14 1924

20-UNDERTAKER: Wm Fuchs & Sons — ADDRESS: Norelton Pa

IMPORTANT—Entries must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84819

CERTIFICATE OF DEATH.

D 84819

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 540 N. Fulton St., 20 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edgar Mann

(a) Residence No. 540 N. Fulton Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary E. Mann

6-DATE OF BIRTH (month, day and year) Aug 7 1883

7-AGE. 40 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9-BIRTHPLACE (city or town) Richmond
(State or Country), Va

PARENTS.

10-NAME OF FATHER, John Mann Jr

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Md

12-MAIDEN NAME OF MOTHER, Alice P. Hill

13-BIRTHPLACE OF MOTHER (city or town) Lewiston
(State or Country), N.Y.

14- (Informant) Mrs. Mary E. Mann

(Address) 540 N. Fulton Ave

15- Filed MAR 13 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from February 10, 1924, to March 12, 1924, that I last saw him alive on March 11, 1924 and that death occurred, on the date stated above, at 12 30 Am.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis with Hypertrophy dilatation and decompensation

(Duration) — yrs. Old mos. — ds.

CONTRIBUTORY (Secondary) Tonsilitis and Rheumatism

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical examination

(Signed) Maurice E. Shamer M. D

3/13, 1924 (Address) 3300 N. Howard ave,

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL, ..., 1924

20-UNDERTAKER Wm. J. Richardson & Son ADDRESS North & Pa.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84819

1-PLACE OF DEATH

City of BALTIMORE: (No. 540 N. Fulton St., 20 Ward) 90

2-FULL NAME Charles Edgar Mann

(a) Residence No. 540 N. Fulton Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary E. Mann

6-DATE OF BIRTH (month, day and year) Aug 7 1883

7-AGE. 40 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9-BIRTHPLACE (city or town) Richmond
(State or Country), Va

PARENTS.

10-NAME OF FATHER, John Mann Jr

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Md

12-MAIDEN NAME OF MOTHER, Alice P. Hill

13-BIRTHPLACE OF MOTHER (city or town) Lewiston
(State or Country), N.Y.

14- (Informant) Mrs. Mary E. Mann

(Address) 540 N. Fulton Ave

15- Filed MAR 13 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from February 10, 1924, to March 12, 1924, that I last saw him alive on March 11, 1924 and that death occurred, on the date stated above, at 12 30 Am.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis with Hypertrophy dilatation and decompensation

(Duration) — yrs. Old mos. — ds.

CONTRIBUTORY (Secondary) Tonsilitis and Rheumatism

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical examination

(Signed) Maurice E. Shamer M. D

3/13, 1924 (Address) 3300 N. Howard ave,

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL, ..., 1924

20-UNDERTAKER Wm. J. Richardson & Son ADDRESS North & Pa.

WHITE PAPER. Certificates should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84820

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2019 N. Fulton Ave. St., 15 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Storm

(a) Residence No. 2019 N Fulton Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Storm

6-DATE OF BIRTH (month, day and year) Dec. 3, 1860

7-AGE. 63 yrs. 3 mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hotel Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer Belvidere

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Fredk H. Storm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Mary Storm

(Address) 2019 N Fulton Ave

15- Robert P. Harrison, 19?

Registrar.

MAR 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 12 1924, that I last saw him alive on March 12 1924, and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic (Bright's) Nephritis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis & Dilatation

(Duration) — yrs. 2 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. E. Grosse M. D

3-13, 1924 (Address) 5016 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cem.	Mar 15. 1924
20-UNDERTAKER. Wm Fickus & Sons	ADDRESS. Norfolk Va

WHITE PENCIL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital 24 100-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Sarah E. Murphy.

(a) RESIDENCE NO. 1410 Webster ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital

MAR 13 1924 Albert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1923, to Oct. 15, 1923, that I last saw her alive on Mar. 11, 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Findings

(Signed) J. Goldsmith M. D.

3/12/1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL March 14, 24

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D 84822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84822

1-PLACE OF DEATH City of BALTIMORE, (No. Union Memorial Hospital St., 27 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gracella Hughes

(Residence in Baltimore: No. 4404 Reedy ave St.; 13 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fr.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Mar. 10 1903 (Month) (Day) (Year)

7-AGE: 21 yrs. 4 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Typist (b) General nature of industry, business, or establishment in which employed (or employer): 609

9-BIRTHPLACE, (State or Country): Ireland.

PARENTS.

10-NAME OF FATHER: Joseph Hughes

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Cathrine O'Farrell

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Hughes

(Address) 4404 Reedy ave

15- MAR 13 1924 Robert P. Harrison, Registrar.

192.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Mar. (Month) 10 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from a Electric car Accident (Accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrissey M. D. (Coroner.)

192 4 (Address) 3232 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Mar 14 1924
20-UNDERTAKER,	ADDRESS
C. A. Niedfeldt, Jr.	501 E. 22nd St.

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FILE COPY

Spec.—1-10-21—M&T—1500 Blks.

(Owens)

D 84823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84823

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 25th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary A. Owens

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Unk.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	78	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot Co
(State or country) Georgia

PARENTS

10 NAME OF FATHER Allen F. Owens

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Emma L. Mathews

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) S. Carolina

14 Informant Records of Mt Hope Retreat
(Address) Baltimore Md.

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1924

17

I HEREBY CERTIFY, That I attended deceased from July 13th 1921, 19—, to March 13th 1924, that I last saw her alive on March 12th 1924, and that death occurred, on the date stated above, at abt 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Complicated by Chr. Val. Disease of Heart (Mitral)

abt (duration) 3 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Dementia Senili

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington DC

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

March 13, 1924 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL March 15 1924

20 UNDERTAKER J. MOWEN COMPANY
WILLIAM F. WOODEN, Successor

ADDRESS 108 W. NORTH AVE

AR 13 1924

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OLD DARK S·A·F·E

Spec.—1-10-21—M&T—1500 Bks.

D 84824

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84824

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Abbottson Jr. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Richmond

(a) RESIDENCE No. 1743 Abbottson Jr. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Richmond

6 DATE OF BIRTH (Month, day, and year) March 25th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Belfast (State or country) Ireland

PARENTS

10 NAME OF FATHER Mathew Richmond

11 BIRTHPLACE OF FATHER (city or town) Belfast (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Halpen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Stuart K Richmond

(Address) 121 E Lanvale St

15 Filed MAR 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day, and year) March 12th 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1924, to March 12th, 1924, that I last saw he alive on March 11th, 1924, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Fenby Stroup III M. D.

3/12/1924 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 3/15 1924

20 UNDERTAKER Geo J Kuth — ADDRESS 1738 Hanford Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECEIVED FROM ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 522 W. Saratoga St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie McCallum

(Residence in Baltimore: No. 522 W Saratoga St. 6 St (Yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed or Divorced (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1878 (Year)

7-AGE: 26 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country): N. C.

PARENTS.

10-NAME OF FATHER: Dont know

11-BIRTHPLACE OF FATHER, (State or Country): Dont know

12-MAIDEN NAME OF MOTHER: Dont know

13-BIRTHPLACE OF MOTHER, (State or Country): Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hezekiah McCallum

(Address) 522 W. Saratoga St

15- MAR 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 11 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia + Valvular Heart disease

(Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Gorsuch M. D. (Coroner.)

3-13 1924 (Address) 117 W Saratoga St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	3-14 1924
20-UNDERTAKER.	ADDRESS
Daniel Easton	64 Cem

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Dowers)

D 84826

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001

D 84826

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1201 Upton St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Thomas Downs

(a) Residence No. 1201 Upton St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 10-1923

7-AGE, ...yrs. 4 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work no

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto City.

PARENTS

10-NAME OF FATHER James Downs

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER, Martha Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Jane Downs

(Address) 1201 Upton St

15- MAR 14 1924 192... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/12/24

17- I HEREBY CERTIFY, That I attended deceased from 3/10, 1924, to 3/12, 1924, that I last saw him alive on 3/11, 1924, and that death occurred, on the date stated above, at 2P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) H. A. Davis, M. D.

3/13, 1924 (Address) 1200 Jonas Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	3-14, 1924
20-UNDERTAKER.	ADDRESS
Daniel Conlon	Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 84827

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 D 84827

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE. (No. St. Agnes Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna T Reinhard

(a) Residence No. 1807 E 28th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX ~~Male~~ Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year)

7-AGE, 68 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

11- (Informant) Henry Reinhard

(Address) 1807 E 28th St

13- MAR 14 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 12 1924

17- I HEREBY CERTIFY, That I attended deceased from March 7- 1924 to March 12 1924

that I last saw h.. alive on March 12 1924

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Superior Poliomyelitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema.

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) S. Goldeman M. D.

. 19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Mar. 15 1924
20-UNDERTAKER.	**ADDRESS**
Johnson & Cowles	1004 Aisquith st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84828

CERTIFICATE OF DEATH.

82 D 84828

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) (Resident)

2-FULL NAME Sr Mary Dominica Ingram

(a) RESIDENCE NO. Mount Hope Retreat ST., 28th WARD St Elizabeth Home

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 16 ds. How long in U. S., if of foreign birth? Dont Know ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer) 11 Work -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) England

PARENTS

10 NAME OF FATHER Thomas Ingram

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) England

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Retreat - Baltimore Md

15

MAR 14 1924 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 27th, 1924, to March 13, 1924, that I last saw her alive on March 12th, 1924, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

General Neuritis - Post Arterio - Sclerosis -

abt (duration) 3 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Mania Dept. Psychosis -

abt (duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

March 13, 1924 (Address) Mount Hope retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Elizabeth Home Ground	March 14 1924
20 UNDERTAKER Henry J Watkins & Co	ADDRESS Edmondson Ave & Collington Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

(George D Sewell) ✓

D 84829 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84829

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 332 S Clinton St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Geo D Sewell

(a) Residence No. 332 S Clinton St., 26 Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A Sewell.

6-DATE OF BIRTH (month, day and year): Oct. 17, 1857

7-AGE, 66 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Geo. Sewell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14- (Informant): Mrs Mary Sewell

(Address): 332 S Clinton St

15- Filed MAR 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Month 12-1924

17- I HEREBY CERTIFY, That I attended deceased from Mch 6, 1924, to Mch 12, 1924, that I last saw h.. alive on Mch 12, 1924, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank A. Glontz, M. D.

Mch 13 1924 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL, Mch 15, 1924

20-UNDERTAKER: L Lemmon — ADDRESS 32 Broad

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Beale

(a) RESIDENCE No. 1724 Druid Hill Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Blk.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife of~~: Mamie Beale,

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Unknown. Va.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hospital

MAR 14 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1924 to Feb. 4, 1924.

that I last saw ~~him~~ alive on Mar. 11, 1924,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio Pneumonia

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Esophagus

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of Unknown

Was there an autopsy? No.

What test confirmed diagnosis? Clynical Findings

(Signed) N. F. Dorsett, M. D.

, 19 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 3/14 1924

20 UNDERTAKER: Mrs James N. Dennis — ADDRESS: 1303 Bressman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 34831

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH ×

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Melvin Coates

(a) RESIDENCE NO. Sparrows PT. Box 54 Route 10, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5 If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Sept 22 1920

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
3	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Melvin Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jessie Ruzzin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 14 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924 to March 12, 1924.

that I last saw him alive on March 12, 1924.

and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows

Tuberculous meningitis

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) ×

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) H. B. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
La Plata Md. via Penn R.R.	Mar 14 24
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 84832 **CERTIFICATE OF DEATH.** 32 D 84832

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wyche

(a) Residence No. 849 Lemmon st. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1894

7-AGE. 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER. Herbert Wyche

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records

(Address) M.C.H.

MAR 14 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

1239

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 9,1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 ....., 19.24, to March 9 ....., 19.24,

that I last saw him alive on March 9 19.24,

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(Duration) ..... yrs. 23 mos. ..... ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L. A. Lally M. D

3-9-24 19 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19....
20-UNDERTAKER,	ADDRESS

UNIVERSITY OF MARYLAND Commissioner Health. MAR 14 1924

THE [illegible]

I. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

47

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84833 **CERTIFICATE OF DEATH.** 38 D 84833

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John H. Briggle

(a) Residence No. 801 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md (State or Country)

PARENTS.

10-NAME OF FATHER. Henry Briggle

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country)

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country)

11- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 14 1924 ROBERT R. KRAMER, Registrar.

1238 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-12-24

17- I HEREBY CERTIFY, That I attended deceased from 6-25, 1923 to 3-12, 1924 that I last saw h— alive on 3-11, 1924 and that death occurred, on the date stated above, at 2 10 a.m.

The CAUSE OF DEATH* was as follows

Syphilis; Syphilitic Aortitis; Aortic Insufficiency (Duration) 2 yrs (Estimated) mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) Claude B. Grace M. D.

3-12, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
UNIVERSITY OF MARYLAND	MAR 14 1924
20-UNDERTAKER.	ADDRESS
Commissioner Health	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

87

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-6 D 84834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Droll

(a) RESIDENCE NO. 3820 Mt Pleasant ave ST., WARD Highlandtown

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Droll

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Louis Hartman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Emma A. Bauer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Joseph Droll (Address) 3820 Mt Pleasant av

15 MAR 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1924, to Mar. 12, 1924, that I last saw h.e alive on Mar. 12, 1924, and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of B-12-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 3/15 1924

20 UNDERTAKER Philip Henig — ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Blks.

D 84835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1129 D 84835

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 48 Forrest View Ave (Belmont) ST., 2 WARD)

2-FULL NAME Rebecca Binyon

(a) RESIDENCE NO. 48 Forrest View Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Late Lieut. Thos. Binyon

6 DATE OF BIRTH (month, day, and year) Oct 21/53

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Mrs D. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah H. Sprague

(Address) 48 Forrest View Ave

15

MAR 14 1924

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1920, to Mar 13, 1924.

that I last saw h-- alive on Mar 12, 1924.

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) X yrs. X mos 5 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) 4 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Edw Talbott, M. D.

3/13, 1924 (Address) 1353 Wrathaven

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 3/17 1924

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

170326 D 84836

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-801 84836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) ... ST., 3 WARD)

2-FULL NAME Infant Potts

(a) RESIDENCE NO. 427 S. Spring St. ST., ... WARD ...
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER William Potts
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.
12 MAIDEN NAME OF MOTHER Paul Johnson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

16 Informant Records.
(Address) JOHNS HOPKINS HOSPITAL

MAR 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 12, 1924, that I last saw her alive on March 12, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary) X
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Born at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) H. H. Weed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	March 15 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 31

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Roady

(a) Residence No. 1216 McCulloh st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1881

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Editor

(b) General nature of industry, business, or establishment in which employed (or employer): Newspaper

(c) Name of employer: Afro-American

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER: Thomas Ball

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Isadore Malone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed MAR 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 4 1924 to March 13 1924, that I last saw h.. alive on March 13, 1924, and that death occurred, on the date stated above, at 1.15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, sputum

(Signed) L. A. Lally M. D

3-13-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Dr Aurlon	March 15 1924
20-UNDERTAKER. Orrz R A Elliott	ADDRESS 1725 Ashland Ave

N. B.—WHITE PLAINLY, with ink. All items must be filled. Exact statement of OCCUPATION is very important. See should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84838 — 100-001 — D 84838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH House of the Good Shepherd

CITY OF BALTIMORE: (No. Fremont & Collins ST.: 20 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Joseph Willems

(a) RESIDENCE. No. Fremont & Collins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced ~~(HUSBAND of~~ (or) WIFE of Joseph Willems

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	92	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of Good Shepherd

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria Germany

PARENTS

10 NAME OF FATHER John Buechner

11 BIRTHPLACE OF FATHER (city or town) Bavaria (State or country)

12 MAIDEN NAME OF MOTHER Theresa Melchior ??

13 BIRTHPLACE OF MOTHER (city or town) Bavaria (State or country)

14 Informant House of Good Shepherd
(Address) Fremont & Collins Sts

MAR 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9th, 1924, to March 12th, 1924, that I last saw her alive on March 11th, 1924, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Pulmonary Oedema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Unknown except age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. A. Shatard, M. D.

March 13 1924 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
House of Good Shepherd	3/14/1924
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons.	1318 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 34839

D 34839

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4078 Monrad ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Wilson

(a) RESIDENCE NO. 4078 Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin F. Wilson

6 DATE OF BIRTH (month, day, and year): Unknown 1865

7 AGE: 58 Years | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: 0

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: B. F. Wilson

(Address): 4078 Monroe St

15

MAR 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12" 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1 , 1924 , to March 12 , 1924 .

that I last saw her alive on March 12 , 1924 ;

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Myocarditis

High blood pressure, Chronic

interstitial Nephritis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (Embolic)

and Coma. (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Tibbett, M. D.

March 12 , 1924 (Address) 2220 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prairie Cemetery — DATE OF BURIAL: March 15" 1924

20 UNDERTAKER: Chas. H. Cook — ADDRESS: 1003 N. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Everything on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks. (See letter in file March 17-1924.)

D 84840 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 84840

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal tuberculosis Hospital 2 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theofil Niznik

(a) Residence No. 1938 Bank st. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Stella Niznik

6-DATE OF BIRTH (month, day and year): ~~1878~~ July 15 1880

7-AGE: 43 - 8 - 3
46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS:

10-NAME OF FATHER: Leon Niznik

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Stanntowa Magdalinski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant): Hospital Records

(Address): M. T. H.

15- MAR 14 1924 ROBERT R. KRAUER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 30 19 24 to March 12 19 24

that I last saw him alive on March 12 19 24,

and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) L. A. Kelly, M. D

3-13- 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: Mch. 15 1924

20-UNDERTAKER: F. H. Ozazeuski

ADDRESS: 1930 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Clayton Koons)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84841

CERTIFICATE OF DEATH.

10-001 • D 84841

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clayton Koons

(a) RESIDENCE NO. 15 E. Hill St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Koons

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kemp

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Information
(Address)

15 Filed MAR 14 1924 ROBERT R. KRAUTER,
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/24

17

I HEREBY CERTIFY, That I attended deceased from 3/7/24, 19..., to 3/12/24, 19...,
that I last saw h~~e~~ ~~alive~~ on 3/12/24, 19...
and that death occurred, on the date stated above, at 7.20 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Cardiac failure,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Bolley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown Md.

DATE OF BURIAL 3-15 1924

20 UNDERTAKER F. A. Dausch & Son

ADDRESS 703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84842

CERTIFICATE OF DEATH.

101 D 84842

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 12 Morgan ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar P Brown

(a) RESIDENCE NO. 12 Morgan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Curtis Bay Co Foundry

9 BIRTHPLACE (city or town) (State or country) Glenburnie Md

PARENTS

10 NAME OF FATHER Solomon Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Glenburnie Md

12 MAIDEN NAME OF MOTHER Elsby Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Glenburnie Md

14 Informant Rosie Brown

(Address) 12 Morgan st

15

MAR 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/7/24, to 3/12/24, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 4.00 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Oc Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

3/13/24 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Mar 15 1924
UNDERTAKER	ADDRESS
Wm G Hooper	906 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAME should be stated EXACTLY. PHYSICIANS should write mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84843

100-001

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Motherhouse of Notre Dame St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Corbiniana Ottenbein

(a) Residence No. Aisquith St & Oakland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov - 26 - 1862

7-AGE, 61 yrs. 3 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Duties D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Leopold Ottenbein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Zauet

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Sister M. Wiemuth

(Address) Notre Dame Aisquith St

15- Filed ..... 192 ..... Registrar.

MAR 14 1924

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 12-1924

17- I HEREBY CERTIFY, That I attended deceased from March 5, 1924, to March 12, 1924, that I last saw h.er alive on March 12, 1924, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

B Mich / Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J J Kirby M. D.

3/13, 1924 (Address) 110 E Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Notre Dame Cliftwood — DATE OF BURIAL, March 15, 1924

20-UNDERTAKER, Frank A. Fink — ADDRESS 915 N Gay St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 84844

D 84844

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-801

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Immaculate Conception ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Ancilla Dernbach

(a) RESIDENCE. NO. Lexington St ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25 - 1870

7 AGE	53 Years	2 Months	27 Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Francis Dernbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Crescentia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sister Mary Bernadine
(Address) Notre Dame, Baltimore, Md.

15 Filed MAR 14 1924, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March - 13 1924

17

I HEREBY CERTIFY, That I attended deceased from March - 3, 1924, to March - 13, 1924, that I last saw h.r. alive on March - 13, 1924, and that death occurred, on the date stated above, at 10 - p. m.

The CAUSE OF DEATH* was as follows:

Bowels pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Kelly, M. D.

3/14, 19 24 (Address) 1105 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md.	March 15 19 24
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay.

N.B.—WRITE PLAINLY. WITH CARE mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84845

CERTIFICATE OF DEATH.

001 ✓

15 D 84845

REGISTERED NO.

1-PLACE OF DEATH Monument & Rutland Ave

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Benjamin F. Myers

(a) RESIDENCE NO. 244 W. Lanvale St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. -- mos. -- ds. How long in U. S. if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	58	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Deputy Collector 08

(b) General nature of industry, business, or establishment in which employed (or employer): Internal Revenue

(c) Name of employer: U. S. Government

9 BIRTHPLACE (city or town) Bethel

(State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER Rev. B. F. Myers

11 BIRTHPLACE OF FATHER (city or town) Carlisle

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Virginia B. Bull

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.

(State or country) Maryland

14 Informant Mrs. Millie Raine Cassiday

(Address) 1351 W. Grand Ave, Springfield

15 Filed MAR 14 1924 19 Robert P. Harrison, Jr.

Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 13 1924, to March 12, 1924, that I last saw him alive on March 12, 1924, and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

4 mos.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Left hemiplegia

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Isidor S. Jaffe, M. D.

Mar 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Ch. Cem. Montgomery CO. Md.

DATE OF BURIAL 3/15 1924

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

B.—WRITE PLAINLY, WITH UNFADING INK. All the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 84846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84846

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 6009 York Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Copeland Codd

(a) Residence No. 6009 York Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 29 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Irma Mohler

6-DATE OF BIRTH (month, day and year) Aug. 13, 1858

7-AGE. 65 yrs. 6 mos. 29 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: President

(b) General nature of industry, business, or establishment in which employed (or employer): Codd Tank and Specialty Co.

(c) Name of employer:

9-BIRTHPLACE (city or town). (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Edward James Codd

11-BIRTHPLACE OF FATHER (city or town). (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Avarilla Hooper

13-BIRTHPLACE OF MOTHER (city or town). (State or Country) Maryland

14- (Informant) James Edw. Codd

(Address) 102 E. 22nd. St.

15- MAR 14 1924 19?? Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 12. 1924.

17- I HEREBY CERTIFY, That I attended deceased from Mar. 2 1924 to March 12 1924

that I last saw h[e] alive on March 12 1924

and that death occurred, on the date stated above, at 3-40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Pulmonary Edema

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. 3+ mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Gibson Poole, M. D

3/14 1924 (Address) 422 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	3/12 19 24
20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 84847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 84847

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Walter MacDonald

(a) RESIDENCE No 219 Goodwood Road, St. Hamilton WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/3/1923.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	10.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisiana, Texas.

PARENTS

10 NAME OF FATHER John Walter MacDonald

11 BIRTHPLACE OF FATHER (city or town) La. (State or country)

12 MAIDEN NAME OF MOTHER Martha Miller

13 BIRTHPLACE OF MOTHER (city or town) La., (State or country) Texas.

14 Informant Mother

(Address)

15 Filed ....., 19 Robert P. Harrison, Registrar

MAR 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1924.

17

I HEREBY CERTIFY, That I attended deceased from 1/24/, 1924, to 3/13/, 1924, that I last saw h... in alive on 3/13/24, 1924, and that death occurred, on the date stated above, at 1:28 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions, probably toxic in nature

Rachitis & anaemia

uncerta... (duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pharyngitis

Echo... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL March 15 1924

20 UNDERTAKER Wendell Oppelt & Son

ADDRESS 0781 N.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Age may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84848

CERTIFICATE OF DEATH.

D 84848

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1929 W Lexington ST., 20 WARD)

2-FULL NAME Carroll G Christ

(a) RESIDENCE NO. 1929 W Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced, (write the word)~~
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 4th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sidney Christ

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Rilla Drake

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Sidney Christ
(Address) 1929 W Lexington St

15 Filed ..... Robert P. Harrison, Registrar

D 1 4 1924 Burial Permit clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should state AGE, should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1924, to Mar 13, 1924.

that I last saw h— alive on Mar 13, 1924.

and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Measles (duration) ..... yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? (Unreadable)

(Signed) James H Strasburg M. D.

3/14 1924 (Address) 17 W Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HARRISONBURG VA

DATE OF BURIAL 3/15 1924

20 UNDERTAKER ROBERT BROOKS & SON

ADDRESS CALHOUN HOLLINS ST

Cor.—1-12-23—M&T—100 Bks.

D 84849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 84849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabella Ritche

(a) RESIDENCE NO 535 Robert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Ritchie

6 DATE OF BIRTH (month, day, and year) unknown - 847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co
(State or country) Md

PARENTS

10 NAME OF FATHER Chapman Burch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Cole

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Arthur Ritchie
(Address) 535 ROBERT ST

15 Filed MAR 14 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
(Burns-clothes caught fire from stove on Feb 23/24)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Oaten, M. D.
(Coroner.)

Mar 14/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. View Cathedral Cem	3/14 1924
20 UNDERTAKER Samuel Hensley	ADDRESS 2132 Edle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&B 1500 Bks.

1986 B

HEALTH DEPARTMENT—CITY OF BALTIMORE

1986 84850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH John Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

REGISTERED NO. 1986 84850

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Hunter

(a) RESIDENCE No. 428 Wilson Terrace ST. Govans, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	46	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Agnes Stanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Record (Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

Robert F. Harris
Burial Permit Clerk.

MAR 14 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to March 11, 1924.

that I last saw her alive on March 11, 1924,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Femoral Thrombosis - about 10 days duration
Pulmonary embolism - occurred immediately before death.

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myomata uteri. Hypertension chronic nephritis myocardial changes

(Duration) 10 mos. ds.

18 Where was disease contracted if not at place of death? at above address

Did an operation precede death? Yes Date of Feb 25, 24.

Was there an autopsy? No.

What test confirmed diagnosis? Operation confirmed Path. of myomata

(Signed) Richard W. Te Linde, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 3/15 1924

20 UNDERTAKER Samuel L Hawsley

ADDRESS W Biddle

P. S.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84851

1-PLACE OF DEATH 1137 Lexton at Monell Park

City of BALTIMORE: (No. ~~Carl Smith Moeller~~ St., ~~Carl Smith Moeller~~ Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Smith Moeller

1137 Lexton at Edmondale Park

(a) Residence No. ~~Carl Smith Moeller~~ St., 25th Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, ~~Divorced~~ (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 1. 1920

7-AGE. 4 yrs. 2 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER. George H. Moeller

11-BIRTHPLACE OF FATHER (city or town) Balto Co. (State or Country), Md

12-MAIDEN NAME OF MOTHER. Margaret E. Smith

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14- (Informant) Mr. George H. Moeller

(Address) 1137 Lexton at Edmondale Park

15- Filed MAR 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from 3-9- 1924 to 3- ~~14~~ 13 1924

that I last saw h~~e~~ alive on 3-13- 1924

and that death occurred, on the date stated above, at 10 15 ~~9~~ m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. B. Hall M. D

3, 13 1924 (Address) Woolford Hospital Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	March 17 1924
20-UNDERTAKER. Jos Joerdens Son	ADDRESS 2173 S. Pace

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 9 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Royston

(a) RESIDENCE NO. 2713 Trinity Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Acie Royston

6 DATE OF BIRTH (month, day, and year) Jan 14 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	2	c	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wolf Hammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Deffler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Margaret C. Hammer (Address) 2713 Trinity Ave

15 Filed APR 14 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-8, 1924, to 3-12, 1924, that I last saw her alive on March 12, 1924, and that death occurred, on the date stated above, at 10 15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bilateral Salpingitis Non Specific

(duration) 0 yrs. 2 mos (?) ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 11/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. Reyler M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Mar 15 1924
20 UNDERTAKER Jos Joerdens Son	ADDRESS 2172 Pac.

G. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84853

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 W. Hill St., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almira V. Gardner

(a) RESIDENCE NO. 144 W. Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hon W. Gardner

6 DATE OF BIRTH (month, day, and year) May 3 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor 019

(b) General nature of industry, business, or establishment in which employed (or employer) Confectionery Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John T Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Bessie Arnold (Address) 1144 W. Hill St

15 MAR 14 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr, 5, 1923, to Mar, 13, 1924, that I last saw her alive on Mar, 13, 1924, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urine - fenton -

(Signed) Dan Francis M. D.

3/14, 1924 (Address) 126 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Mar 17 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIAN'S AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84854 ✓ D 84854

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 2822 Hudson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salomeya Popiacka

(a) Residence No. 2822 Hudsn St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sep. 5 1850

7-AGE,	If LESS than 1 day,
73 yrs. 6 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Uknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Uknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Mr. Marion Frankowski

(Address) 2822 Hudson Street

15- Filed MAR 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 14/24

17- I HEREBY CERTIFY, That I attended deceased from March 12, 1924, to March 14, 1924, that I last saw her alive on March 14, 1924, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis.

(Duration) 5 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & Symptoms

(Signed) John V. Szerlicka, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	March 17, 1924
20-UNDERTAKER.	ADDRESS
John A Weber	1803 Bank St

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 84855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospl ST., V WARD)

2-FULL NAME Chas Hetz

(a) RESIDENCE NO. 810 S. Broadway, WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Elizabeth Hetz

6 DATE OF BIRTH (month, day, and year) Sept. 16 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER George Hetz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Hetz

(Address) 4326 Roslyn Rd.

15 Filed APR 14 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-1924

17

I HEREBY CERTIFY, That I attended deceased from 3.6.24, 19..., to 3.13.24, 19...,

that I last saw h. ~~me~~ alive on 3.13.24, 19...,

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Ch. Endocarditis & Myocarditis

" Dest Myocarditis

Congestive Dem

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremic Poisoning

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno A Thompson, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	3/15th 1924
20 UNDERTAKER John A. Moran	ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84856

CERTIFICATE OF DEATH.

12 14-001

D 84856

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2223 N. Calvert St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nannie Heatherby Simmons

(Residence in Baltimore: No. 2223 N. Calvert St.

St.: yrs., — mos. 05 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, April (Month) 8 (Day), 1863 (Year)

7-AGE, 60 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Emory Heatherby

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Mary DeBruler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clarence M. Shipley

(Address) 2223 N. Calvert St.

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MAR 15 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 14 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) John H. Russell M. D.
(Coroner.)

Mar 20, 1924 (Address) 232 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State...Life mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Adamstown Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Frederick Md.	March 15, 1924
20-UNDERTAKER Horace H. Burgee	ADDRESS 363 Walbrook

*GENERAL INSTRUCTIONS.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84857

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84857

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 524 West West St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lucian B. Foote

(a) Residence No..... 524 West West St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 11, 1923

7-AGE, 1 yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William L. Foote

11-BIRTHPLACE OF FATHER (city or town) Calvert Co.
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Inez M. Brown

13-BIRTHPLACE OF MOTHER (city or town) Chesterton
(State or Country), Kent Co. Md.

14- (Informant)... Inez Foote

(Address)... 524 West St

15-

Filed ..... 192 ..... Registrar.

MAR 15 1924 Robert P. Harrison

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13 1924

17- I HEREBY CERTIFY, That I attended deceased from March 7, 1924 to March 13, 1924

that I last saw h.. alive on March 12, 1924

and that death occurred, on the date stated above, at 10½ A. m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

6.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Fruhinger M. D.

3/14, 1924 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt. Auburn	Mch 15 1924
20-UNDERTAKER,	ADDRESS
John H. Toadvine	1412 Druid Hill Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84858

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME. Dorothy Jefferson

(a) RESIDENCE NO. 1421 St. Mathews St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Edna Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL.

15 Filed MAR 15 1924, 19 Robert F. Harrison, Registrar

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1924 to March 13, 1924. that I last saw h.e alive on March 13, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(duration) ..... yrs. ..... mos. 1 da.

CONTRIBUTORY (Secondary) Pneumococcus meningitis (duration) ..... yrs. ..... mos. 2 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund N Kelser, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	March 15 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

MAR 15 1924

Spec.—1-10-21—M&T—1500 Bks.—WRITE PLAINLY WITH UNFADING INK. PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84859

CERTIFICATE OF DEATH.

101-D 84859

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 Mulliken ST., 6 WARD)

2-FULL NAME John H. Jones

(a) RESIDENCE NO. 1741 Mulliken ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant ..... Julia Stream
(Address) 1741 Mulliken

Registered 5 1924 Kelsey P. Harrison, 19
Deputy Health Officer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-24

17 I HEREBY CERTIFY, That I attended deceased from 3-12-, 1924, to 3-13, 1924, that I last saw h... alive on 3-12-, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Clyde Symns, M. D.

3-13 1924 (Address) 201 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burr cemetery

DATE OF BURIAL 15 mar 24

20 UNDERTAKER Edward Gr...

ADDRESS ...

—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be careful to mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to AUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OPA- ION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84860

CERTIFICATE OF DEATH. 101-00

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 5 WARD)

2-FULL NAME Herbert March

(a) RESIDENCE NO. 146 N. Exeter St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct 11 1899

7 AGE: Years 24 | Months 5 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Gas and Electric Co

9 BIRTHPLACE (city or town) (State or country) Balto and.

PARENTS

10 NAME OF FATHER Wesley Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catharine Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record
(Address)

15 Filed MAR 15 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/9/24, 19..., to 3/14/24, 19..., that I last saw h alive on 3/14/24, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute cardiac failure

..... (duration) ... yrs 3 hrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odd Fellows Cemetery — DATE OF BURIAL 3/17/1924

20 UNDERTAKER W M S Cook — ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146

D 84861

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST. 23 WARD)

2-FULL NAME Mrs Hallie Goldsborough Young.

(a) RESIDENCE No. 918 Hanover St ST., ... WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas L. Goldsborough Young

6 DATE OF BIRTH (month, day, and year) June 15 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Gord.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Hallie Goldsborough Young (Address) 918 Hanover St

15 Filed APR 15 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.11.24

17 I HEREBY CERTIFY, That I attended deceased from 3.10.24, 19..... to 3.11.24, 19.....

that I last saw h... alive on 3.11.24, 19.....

and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows: A

Pneumococcal Sepsis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. 6 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Md General Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Mar 15 1924

20 UNDERTAKER Leonard Cook ADDRESS 928 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84862

D 84862

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 Rabnq ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jessie Brown.

(Residence in Baltimore: No. 739 Rabnq St.; 75 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Dec (Month) 3 (Day), 1885 (Year)

7-AGE. 38 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto.

PARENTS.

10-NAME OF FATHER. Vincent Lewis.

11-BIRTHPLACE OF FATHER (State or Country). Wash. D.C.

12-MAIDEN NAME OF MOTHER Sara Scott.

13-BIRTHPLACE OF MOTHER (State or Country). Wash. D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Brown.

(Address) 739 Rabnq

15-

Filed ....., 192.. Robert P. Harrison, Registrar.

Buried Friedl Clerk.

MAR 15 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 12 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-7 1924, to March 12 1924, that I saw h[illegible] alive on March 12 1924, and that death occurred, on the date stated above, at 3 05 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism (Chronic)

(Duration) 20 yrs. mos. ds.

(Signed) H. T. King M. D.

3-13, 1924 (Address) 645-1 W. Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Zion

DATE OF BURIAL. Mar 15, 1924

*UNDERTAKER

ADDRESS

B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If UNDER ONE DAY, HOURS or MINUTES. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84863

100-001

D 84863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Webster

(a) RESIDENCE No. 1114 Carrollton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of HUSBAND of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60-70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records

(Address)

15 Filed APR 15 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-12, 1924, to 3-12, 1924

that I last saw her alive on 3-12, 1924

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Thomas, M. D.

3-13 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Mar 17 1924

UNDERTAKER R Watson — ADDRESS 1405 McElderry

Burial Permit Filed

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2011 E. Preston St., 8 Ward) Registered No. 154-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph B. Ehrr Jr.

(a) Residence No. 2011 E Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 7 1924

7-AGE. yrs. 2 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph B. Ehrr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Olevia M. Keene

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dorchester Co Md

14- (Informant) Mr. Joseph B. Ehrr

(Address) 2011 E. Preston St.

15- Filed Mar 15 1924 Robert P. Harrison Registrar.

AR 151924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 14 1924

17- I HEREBY CERTIFY, That I attended deceased from March 13 19 24 to March 14 19 24

that I last saw him alive on March 14 19 24

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1-

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dawes Miller, M. D

, 19 (Address) 1506 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Mar. 17, 1924
20-UNDERTAKER.	ADDRESS
Henry Storch Son	120 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84865

CERTIFICATE OF DEATH.

D 84865

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Harford ave ST.; 9 WARD)

2-FULL NAME Wm. E Litz Jr

(a) RESIDENCE. NO. 1700 Harford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-14-24

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Wm E Litz

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Wyszatch Meyers

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Wm E Litz Jr.
(Address)

15 Filed , 19 Robert P. Harrison, Registrar

MAR 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-14, 1924, to 3-14, 1924, that I last saw him alive on 3-14, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale 9 hr.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Patent foramen Ovale 9 hr.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? -

What test confirmed diagnosis? Clinical signs

(Signed) Deane Allen, M. D.

, 19 (Address) 2062 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	March 18th 1924

20 UNDERTAKER	ADDRESS
Henry Hosch & Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 84866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at

City of BALTIMORE: (No. Franklin & Green Hospital St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathan Campbell

(Residence in Baltimore: No. 718 N Vincent St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: Unknown
(Month) (Day) (Year)

7-AGE: 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tobacco
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Balto Co

PARENTS.

10-NAME OF FATHER: Campbell

11-BIRTHPLACE OF FATHER, (State or Country): Balto Co

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E Campbell

(Address) 1719 Baker St

15- Filed MAR 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 12 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Benton M. D. (Coroner.)

Mar 13 1924 (Address) 704 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem DATE OF BURIAL: Mch 16th 1924

20-UNDERTAKER: A. Jones ADDRESS 111 S. Gilmor

18

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84867

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

D 84867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jinnie Williams

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885

7-AGE,	If LESS than 1 day,
39 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Virginia
(State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ?
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ?
(State or Country),

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed MAR 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-12-24

17- I HEREBY CERTIFY, That I attended deceased from 1-24, 1924 to 3-12, 1924 that I last saw h alive on 3-11, 1924 and that death occurred, on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis (?)
Aortic Insufficiency
Myocardial Insufficiency

(Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Claude A. Dean M. D.

3-12, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
UNIVERSITY OF MARYLAND.	MAR 15 1924

20-UNDERTAKER. ..... ADDRESS .....

Per. Wm. E. Woodall

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84868 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90 D 84868

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hopkins

(a) Residence No. 218 N. Dunbar St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Maryland (State or Country),

PARENTS.

10-NAME OF FATHER, Wm Hopkins

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

11- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15- Robert P. Harrison, Registrar.

MAR 15 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-13-24

17- I HEREBY CERTIFY, That I attended deceased from 3-12, 1924 to 3-13, 1924

that I last saw him alive on 3-13, 1924

and that death occurred, on the date stated above, at 9 3/4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial degeneration

(Duration) yrs. 1 (hr.) mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude 9 Brace M. D.

3-13, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.

DATE OF BURIAL, ..., 19....

20-UNDERTAKER,

ADDRESS,

MAR 15 1924

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84869

CERTIFICATE OF DEATH.

100-D 84869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospit ST., 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Miller

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Annapolis, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

MAR 15 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 11 19 24

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1923, to 3 - 11, 1924 that I last saw him alive on 3 - 11, 1924 and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchi - Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude S. Drane, M. D.

3-12, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19 .....

20 UNDERTAKER .....

ADDRESS .....

UNIVERSITY OF MARYLAND

MAR 15 1924

P.S.—WRITE PLAINLY, with pen and ink. All information should be stated EXACTLY. PHYSICIANS should state AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84870

CERTIFICATE OF DEATH.

74 D 84870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Augusta Ave. WARD 20)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H Heisse

(a) RESIDENCE No. 431 Augusta Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J Heisse

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Navigation Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md

PARENTS

10 NAME OF FATHER John F. Heisse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Bud[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant E. W. Heisse

(Address) 310 E North Ave

15 Filed MAR 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1924

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 14, 1924, that I last saw him alive on March 13, 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

& Paralysis

(duration) mos 4 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M D.

3-14 1924 (Address) 222 Augusta Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	March 17 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

N. B.—WRITE LEGIBLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84871

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 2800 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Schmitt

(a) RESIDENCE NO. Mount Hope Retreat ST. 2800 WARD Phila. Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? Not Known yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Schmitt

6 DATE OF BIRTH (month, day, and year) July 1st 1848 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Est	75	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): (?) Germany

PARENTS

10 NAME OF FATHER: Andrew Hilf (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country): (?) Germany

12 MAIDEN NAME OF MOTHER: (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (?) Germany

14 Informant: Records of Mt Hope Retreat Baltimore Md.

(Address)

Filed MAR 15 1924, 19 Robert P. Murray Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1923, to March 14th, 1924, that I last saw her alive on March 13, 1924; and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis - Uremic Convulsions -

abt (duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Cyclosis & Senile

abt (duration) 0 yrs. 7 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa. DATE OF BURIAL: Mar 17 19 24

20 UNDERTAKER: [illegible] MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 103 W. [illegible]

Spec.—WHITE PERMIT, white paper supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84872 HEALTH DEPARTMENT—CITY OF BALTIMORE 119-901 D 84872

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. The Royalton St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Willard Sugent

(a) Residence No. The Royalton St., 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? 73 yrs. 4 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L. Sugent

6-DATE OF BIRTH (month, day and year) about Oct-18-1850

7-AGE. About 73 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Eli Sugent

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Emily Barker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland

14- (Informant) Mrs Emma L. Sugent (wife)
(Address) 12 N. Mayfield Ave

15- Robert P. Harrison, Registrar.

MAR 15 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 13-1924

17- I HEREBY CERTIFY, That I attended deceased from March 9, 1924, to March 13, 1924, that I last saw him alive on March 13, 1924, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer —
Gastric Hemorrhage

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Purpura of 1 wk duration

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. L. Watkins, M. D.

Mar 15, 1924 (Address) 224 E. 39th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery — DATE OF BURIAL. Mar 17 1924

20-UNDERTAKER. [illegible] & WOODEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUP[illegible] instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84873

HEALTH DEPARTMENT—CITY OF BALTIMORE

T86-001

D 84873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman J. Emge

(a) RESIDENCE NO. Parkville, ST. Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18 mo.	1	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Parkville Md

PARENTS

10 NAME OF FATHER George P. Emge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Maryland

12 MAIDEN NAME OF MOTHER Margaret McCarrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Maryland

14 Informant George P. Emge

(Address) Parkville Md

15 FEB 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 28th, 1924, to Mar 14th, 1924, that I last saw h[illegible] alive on Mar 14th, 1924, and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (strept mucos)

(duration) yrs mos. 1 ds.

CONTRIBUTORY (Secondary) Otitis Media & Mastoiditis (duration) yrs mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb. 28, 24

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) A. C. Manning M. D.

(Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Monte Marie Cemetery Towson	March 17 24
20 UNDERTAKER	ADDRESS
Fredk Loeschner & Sons	Fallston

B.—WHITE PLAINLY, WITH INK. Typewriting preferred. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84874

CERTIFICATE OF DEATH.

D 84874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3139 Newland Ave ST., 12 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Collins Biddle

(a) RESIDENCE NO. 3139 Newland ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Osborne Biddle

6 DATE OF BIRTH (month, day, and year) Sept 2 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sectary 09

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Builders

(c) Name of employer Pusey & Jones Co. Wilmington Del

9 BIRTHPLACE (city or town) (State or country) New Castle Del

PARENTS

10 NAME OF FATHER Samuel Biddle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Odessa Del.

12 MAIDEN NAME OF MOTHER Eliza Totman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Osborne Biddle
(Address) 3139 Newland ave

15 Filed MAR 15 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby, 1924, to March 13, 1924, that I last saw h[illegible] alive on March 12, 1924, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Ulcers - Stomach

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) immediate yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W G [illegible] M. D.

3/14, 1924 (Address) 725 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Delaware	March 17 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

N. B.—WHITE LEDGER, with CARBON ATTACHMENT, supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS will please state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84875

CERTIFICATE OF DEATH.

3/4 D 84875

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 W. Virginia ave ST., 27 WARD)

2-FULL NAME Joseph S Lucas

(a) RESIDENCE No. 117 W. Virginia ave ST. Dupont Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Pauline Lucas

6 DATE OF BIRTH (month, day, and year) June 15 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania Pa

PARENTS

10 NAME OF FATHER Joseph T. Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Maggie J Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Pauline Lucas

(Address) 117 W Virginia ave

15 Filed MAR 15 1924, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1923, to March 13, 1924, that I last saw him alive on March 13, 1924, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Repair Mechanic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. B. Emmons, M. D.

3-17, 1924 (Address) 5016 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar 17th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK. This certificate should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Nisson)

D 84876

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 84876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3509 York Road ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna T. Nisson

(a) RESIDENCE NO. 3509 York Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 63 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Wisow

5a If married, widowed, or divorced (or) WIFE of Nicholas Nisson

6 DATE OF BIRTH (month, day, and year) Jan 29th 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER H Vonderheide

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER C. Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick N. Nisson
(Address) Bowie Md

15 Filed ..... 19 ..... Registrar

MAR 15 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1924, to March 13, 1924.

that I last saw her alive on March 13, 1924.

and that death occurred, on the date stated above, at 12 A, m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H H Goodwin, M. D.

3.14.1924 (Address) 1111 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 17th 1924
20 UNDERTAKER	ADDRESS
George Schulling & Sons	1136 E Mount 21

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84877

CERTIFICATE OF DEATH.

5

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp St. 14 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Col. Jerome Hoyce

(a) Residence No. 733 N Mark Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 0 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeanette S. Joyce

6-DATE OF BIRTH (month, day and year): Mar 14 1865

7-AGE: 59 yrs. 0 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Hotel Prop.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS:

10-NAME OF FATHER: Eugene T. Joyce

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Margaret Dealey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto

11- (Informant): Mrs Woodruff

(Address): 733 N Mark Ave

13- MAR 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 15 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 22 1924 to Mch 15 1924

that I last saw him alive on Mch 15 1924

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene

(Duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed): S. Goldman M. D

19 (Address) St. Agnes' Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Mar 17 1924

20-UNDERTAKER: Wm Tickner & Sons ADDRESS: North St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84878

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 N. Wolf St. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Fields.

(a) Residence No. 906 N. Wolf St St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	White	Widow

6-If married, widowed, or divorced HUSBAND of (or) WIFE of John H Fields

6-DATE OF BIRTH (month, day and year) 1853.

7-AGE. 70 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at Home

(b) General nature of industry, business, or establishment in which employed (or employer). 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Mills

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant) William Reisig

(Address) 906 N. Wolfe St

15- Filed MAR 15 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-14-24

I HEREBY CERTIFY, That I attended deceased from 3-11-24 to 3-14-24

that I last saw h alive on 3-13-24

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Natural Deficiencies

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Floyd Rupley M.D.

3-14-24 (Address) 906 N. Wolfe St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem'd	Mar 17, 1924
20-UNDERTAKER	ADDRESS
Merlook	508 E Madison

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use UNUSUAL CARE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~JOHNS HOPKINS HOSPITAL~~ 1634 McElderry St

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Sears

(a) RESIDENCE No. 1634 McElderry ST. ..... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 2 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	Col.	Child.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1922

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	1	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER Andrew Sears

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Sally Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Anna B. Sears
(Address) 1634 McElderry St
Date ..... 19 .....

15 Filed MAR 15 1924 19 ..... Burial Permit Clerk ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 1924 to March 5 1924.
that I last saw h[illegible] alive on March 5 1924,
and that death occurred, on the date stated above, at 7 AM.
The CAUSE OF DEATH* was as follows:
Pulmonary Atelectasis

estimated (duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Thoracic Rickets.

? (duration) ..... yrs ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? Physical Examination

(Signed) Casper Fleischner, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashbury Cem. DATE OF BURIAL: Mar 17 1924

20 UNDERTAKER: Robert E. Watkins ADDRESS: 1615 McElderry St

N. B.—WRITE PLAINLY, WITH CRIMINAL ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84880

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 234 S. Durham (St.) V (Ward.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Ball

(a) RESIDENCE. No. 234 S Durham St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Carolus

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE — Years: 48 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: James Ball

(Address) 234 S Durham

15 Filed MAR 15 1924, 19 — Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 2-1 1924 to 3-14 1924, that I last saw h[illegible] alive on 3-13 1924, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows: Valvular Cardiac Dis (Mitral)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Lyde Barnes, M. D.

(Address) 2019 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 3/17/1924

20 UNDERTAKER: Robert E Wilkins — ADDRESS: 1511 N Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84881

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1409 N. Bruce ST., 15 WARD)

2-FULL NAME Edward C. Jones

(a) RESIDENCE NO. 1409 N. Bruce ST., WARD Moseley Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Julia Jones

6 DATE OF BIRTH (month, day, and year) Feb. 4. 7[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesterfield

9 BIRTHPLACE (city or town) (State or country) Chesterfield Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Grace Monford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Frederick Jones 1409 N. Bruce St

15 Filed ..... 19.... Robert P. Harrison, Registrar

Burial Permit Issued

MAR 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 12 1924.

that I last saw him alive on March 11 1924

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart - Complicated Bronchitis Subacute and Cardiac Asthma yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) Gangrene of Rheumatism and Arthritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Columbus M. D.

(Address) 2037 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Moseley Chesterfield Co Va	Mch 15, 24
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 34882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 84882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 802 N. Woodyear ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Oscar Smith

(a) RESIDENCE No. 802 N. Woodyear ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Rosalyn Smith

6 DATE OF BIRTH (month, day, and year) Oct 7-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Porter

(c) Name of employer Murphy Brothers

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm B Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudoun Co Va

12 MAIDEN NAME OF MOTHER Susan Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co. Va

14 Informant Bertha Commodore

(Address) 622 Dolphin St

15 Filed ....., 19.... Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10th, 1924, to Mar. 14th, 1924, that I last saw h[e] alive on Mar. 14th, 1924, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart 60 mins.

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Dr. Edw. J. Bell M.D.

3-14 1924 Address 1224 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 15 1924
20 UNDERTAKER	ADDRESS
Jam. W. Chase & Son	1400 Madison

N. B.—WRITE PLAINLY, WITH CAPACITY INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 15 1924

(Derr)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84883

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84883

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 Park Ave (St.) Wilhelm Park (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Derr

(a) RESIDENCE. NO. 102 Park Ave (St.) Wilhelm Park (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Derr.

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gottlieb Schmuker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wegner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Schmuker. (Address) 102 Park Ave. Wilhelm Park

15 Dec. 19... Registrar

MAR 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1924

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1924, to March 14, 1924, that I last saw h-r alive on March 14, 1924, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Embolic)

Suddenly.

(duration) ... yrs. ... mos. 03 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ... yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Stitch M. D.

3/14/1924 (Address) 2151 Wilhelm Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	March 17, 1924.
20 UNDERTAKER	ADDRESS 3109
Chas. W. Dill.	Fredk. Ave.

Burial Permit Clerk.

MAGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60-002 D 84884

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Dittell

(a) RESIDENCE NO. 1717 Bentalou St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Chas. Dittell

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Record (Address)

15 Filed MAR 15 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/24

17 I HEREBY CERTIFY, That I attended deceased from 3/1/24, 19..., to 3/10/24.

that I last saw h... alive on 3/10/24

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Laryngeal Glanders

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of 3/14/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) N. V. Golley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem'y | DATE OF BURIAL 3/18 1924

20 UNDERTAKER George J. Ruth 1735 | ADDRESS Harford Ave

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84885

CERTIFICATE OF DEATH.

6 57

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2922 E. Baltimore St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Parks

(a) Residence No. 2922 E. Baltimore St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mon. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Parks

6-DATE OF BIRTH (month, day and year) Sept 4 1869

7-AGE, 54 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) ..... D/S
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.
10-NAME OF FATHER, John Parks
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.
12-MAIDEN NAME OF MOTHER Harriett Jones
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mary E. Parks
(Address) 2922 E. Balto St

15- FILED MAR 15 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit, clerk

Ed Moran 2438 Eutaw

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 13 1924

17- I HEREBY CERTIFY, That I attended deceased from July, 19 27, to March 13, 19 24, that I last saw h[illegible] alive on March 12, 19 24, and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 4 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Ulcer of the stomach Hemmorrhages.

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. A. L. A. Meyer M. D.

III. 14. , 19 24 (Address) 2438 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn MD. | DATE OF BURIAL, March 16, 19 24

20-UNDERTAKER. John L Moran | ADDRESS 2438 Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84886

CERTIFICATE OF DEATH.

84 D 84886

REGISTERED NO.

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Roy Beckner

(a) RESIDENCE NO. 1629 W Lafayette ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Conner

6 DATE OF BIRTH (month, day, and year) July 6 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy. 066

(c) Name of employer Bonfils Elec. Balto Md

9 BIRTHPLACE (city or town) (State or country) Elmore E. Beckner

PARENTS

10 NAME OF FATHER Elmore E. Beckner

11 BIRTHPLACE (city or town) Penna

(State or country)

12 MAIDEN NAME OF MOTHER Millie Frederick

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Elmore E. Beckner

(Address) 1629 W. Lafayette ave

15 Filed MAR 15 1924 Robert P. Patterson, Registrar

Burial permit clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/24 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/24, 19, to 3/14/24, 19, that I last saw h. J.M. alive on 3/14/24, 19, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Oper

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Post. Operative Intra ventricular Hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? Yes. Date of 3/14/24

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Mar 17 1924

20 UNDERTAKER: Peter and Lore — ADDRESS: 1223 N. Eutaw St

B. WHERE DEATH occurred should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 84887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 661 Pierce ST., 17 WARD)

2-FULL NAME Mary E. Finney

(a) RESIDENCE NO. 661 Pierce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Finney

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Md Cecil

PARENTS

10 NAME OF FATHER Henry Hodare

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Geo Finney (Address) 661 Pierce St

15 Filed MAR 18 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1924

17 I HEREBY CERTIFY, That I attended deceased from January 30th, 1924, to March 12th, 1924, that I last saw h[er] alive on March 5th, 1924, and that death occurred, on the date stated above, at 730 a. m.

The CAUSE OF DEATH* was as follows:

Acute Phthisis

(duration) 7 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Physician, M. D.

(Address) 607 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Cecil	3/16 1924
20 UNDERTAKER James D. Housley	ADDRESS 578 Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84888

CERTIFICATE OF DEATH.

193 D 84888

1-PLACE OF DEATH Garrett Ave., & B. & O. R. R.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. ..... ST., 24 WARD)

2-FULL NAME Carroll H. Feete

(a) RESIDENCE No ..... Middletown, Md. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 46				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Magazine
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Middletown, Md.

PARENTS

10 NAME OF FATHER H. C. Feete.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Middletown, Md.

12 MAIDEN NAME OF MOTHER Mary E. Null

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland. (Lewistown)

14 Informant Alva D. Feete
(Address) 822 N. Fulton Ave. KRAUTER

15 MAR 16 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10-11 192 '24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to His death on the day stated above.

The CAUSE OF DEATH* was as follows:
Exposure-- storm of Mar. 10-11 '24
(Found at Garrett Ave., near B. & O. R. R. Track -- no marks of injury.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. K. Fallin, M. D.
(Coroner.)
Mar 16, 192 4 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Md. DATE OF BURIAL: 3-16 192 4

20 UNDERTAKER: E. H. Hoke ADDRESS: 1156 West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 84889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14202 ✓

D 84889

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Memorial Hospital. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Cohen

(Residence in Baltimore: No. 2001 Eutaw Place. St.; yrs. 1 wife mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 12 (Day), 1858 (Year)

7-AGE, 65 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Manager
(b) General nature of industry, business, or establishment in which employed (or employer)..... Dept. Store

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Simon Cohen

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Theresa Brafman

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Harold Cohen

(Address) 2002 Eutaw Place

15- MAR 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 13 (Day), 1924. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of a Mod Vessel
as Direct Result of the
Explosion of Ethylene Gas
and Air Mixture
upon Bernard Cohen
(Secondary) Explosion-Accidental
(Duration) ....yrs. ....mos. ....ds.

(Signed) John J. Morrissey M. D.
(Coroner.)

Mar. 15th, 1924 (Address) 3632 R. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Har Sinai Cem. DATE OF BURIAL, 3/16/, 192..

20-UNDERTAKER David Sondheim ADDRESS 118-20 W. Mo... Royal Ave...

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84890

CERTIFICATE OF DEATH.

51

REGISTERED NO.

1. PLACE OF DEATH
D 84890
CITY OF BALTIMORE: (No. 1504 Latrobe Park Drive WARD 24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Cecilia Melba Ziegler

(a) RESIDENCE. No. 1504 Latrobe Park Dr. WARD 24
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8th 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	11	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer) school.
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER George Ziegler
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Mary Ellen Sullivan
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hirsh
(Address) 2202 W. North

15 Filed MAR 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-1- 1923, to 3-14- 1924, that I last saw her alive on 3-13 1924, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:
the Chronic dilatation of heart.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism acute (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual tests.

(Signed) Hirsh, M. D.

19 (Address) 2202 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Co.

DATE OF BURIAL 3-15- 1924

ADDRESS 1501 E Fort Ave

20 UNDERTAKER Chas L Sterns

N. B.—WRITE PLAINLY with ink. All items should be stated EXACTLY. FIGURES should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84891

CERTIFICATE OF DEATH.

11-0 D 84891

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3018 Walbrook Ave ST., 12 WARD)

2-FULL NAME George Martin Mayer

(a) RESIDENCE No. 3018 Walbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Agnes Mayer.

6 DATE OF BIRTH (month, day, and year) Aug 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7.	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Simon Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. F. Mayer.

(Address) 3018 Walbrook

15 Filed MAR 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 24, 19..., to March 13/24, 19..., that I last saw h... alive on March 13/24, 19..., and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Bright Disease 7
(Albuminuria & uraemia).

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Incompetency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 3018 Walbrook Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 3/17 1924

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E. Fay

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84892

CERTIFICATE OF DEATH.

D 84892

1-PLACE OF DEATH

City of BALTIMORE, (No. 2843 W North ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Patrick Doyle

(a) Residence No. 2843 W North ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josie L Doyle

6-DATE OF BIRTH (month, day and year) Feb 16 1859

7-AGE. 65 yrs. mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, Patrick Doyle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret Whalen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs J Doyle

(Address) 2843 W North Ave

15- Filed MAR 16 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 14 24

17- I HEREBY CERTIFY, That I attended deceased from March 10 1924 to March 14 1924

that I last saw h alive on March 13 1924

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

Chr Ex Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas R Lewis M. D.

Mch 14, 1924 (Address) 1504 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL, 3/17/24

20-UNDERTAKER, Enoch A Linky — ADDRESS Tulton & Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Korman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84893

CERTIFICATE OF DEATH.

74-001 ✓

74 D 84893

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 N.Bond ST., 7 WARD)

2-FULL NAME Freida Korman

(a) RESIDENCE No. 1005 N.Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Korman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work AT Home
(b) General nature of industry, business, or establishment in which employed (or employer) died
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E.Balto Md

15 Filed MAR 16 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-Hemorrhage

(duration) yrs. mos ds

CONTRIBUTORY (Secondary) Arteriosclerosis- senility

(duration) yrs. mos. ds.

(Signed) J S H Paul, M. D.
(Coroner.)

Mar 16/24 (Address) 508 E. NOrthAve

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 192 4

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84894 ✓ 13-001 D 84894

D 84894

CERTIFICATE OF DEATH.

5

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1243 St. Matthew St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Weise or Weinstein

(a) Residence No. 1243 St. Matthew St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Max Weise

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 37 yrs. ..... mos. — ds. —

If LESS than 1 day. ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Roumania

PARENTS.

10-NAME OF FATHER. ✓ Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Max Weise

(Address) 1243 St. Matthew St

15- Filed MAR 16 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/15-24

17- I HEREBY CERTIFY, That I attended deceased from 3/14 19 24 to 3/15 19 24

that I last saw her alive on 3/15 19 ..

and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(Duration) ... yrs. ... mos. ... ds. 3 hrs

CONTRIBUTORY (Secondary) Spontaneous abortion

(Duration) ... yrs. ... mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Morris Duplessis M. D

3-15 19 24 (Address) 1118 South Exeter St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL. 3/17 19 24

20-UNDERTAKER Jack Levi's — ADDRESS 1439 E. Balto St

should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84895

CERTIFICATE OF DEATH.

167 D 84895

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 Light St. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Maddox.

(a) RESIDENCE. No. 1928 Light St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie J. Maddox.

6 DATE OF BIRTH (month, day, and year) Sept. 6, 1836.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87,	6,	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Salisbury, Maryland.

PARENTS

10 NAME OF FATHER: Benjamin Maddox.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Sallie White.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Annie J. Maddox, (Wife).
(Address) 1928 Light St.

MAR 16 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1924, to Mar 14, 1924, that I last saw h[illegible] alive on Mar 14, 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Old age

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. P. Campbell, M. D.

Mar 14 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	March 17 1924

20 UNDERTAKER: A. Howard Evans ADDRESS 356 Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 84896

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Minch.

(a) RESIDENCE No. 615 Whitelock ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	wt	infant.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25-15

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Harry L. Minch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Theresa Abrams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) I. Lewis 1439 E. Balto.

15 Filed MAR 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1924, to Mar 16, 1924, that I last saw her alive on Mar 16, 1924, and that death occurred, on the date stated above, at 10 05 m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis.

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) (a) Streptococcus meningitis, and (b) Staphylococcus Salivarius Thrombosis, (duration) at least mos. 22 ds.

18 Where was disease contracted if not at place of death? @ Home.

Did an operation precede death? yes Date of 2/11/24, 2/24/24.

Was there an autopsy? no.

What test confirmed diagnosis? Bld Culture, culture of meningeal exudate

(Signed) Adolf Sondheimer, M. D.

19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodelph

DATE OF BURIAL March 16 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto

N.B. WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 84897

CERTIFICATE OF DEATH.

D 84897

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1301 N. Broadway St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benedetto Bonciogahni

(a) Residence No. 1301 N. Broadway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Bonciogam

6-DATE OF BIRTH (month, day and year) Dec. 8. 1850

7-AGE. 73 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Villa Rosa Italy

PARENTS.

10-NAME OF FATHER, Benedetto Bonciogni

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Gaetano Vukmano

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14-

(Informant) Thomas Bonciogamin

(Address) 1301 N. Broadway

15-

MAR 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 14/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 3 1924 to Mar 12 1924 that I last saw h[illegible] alive on Mar 12 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Rt. Hemiplegia

(Duration) ....yrs. ....mos. 40 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary L. Kitchen M. D

Mar 16 1924 (Address) 1038 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL. March 17 1924

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Hayford ave.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 84898

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 84898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Jefferson ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amanda Scherer Se

(a) RESIDENCE NO. 2219 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Scherer
(Address) 2219 Jefferson

15 Filed ....., 19.....

MAR 17 1924 ROBERT R. KRAUTER, Registrar of Records, Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1924, to Mar 15, 1924, that I last saw him alive on Mar 15, 1924, and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) W. E. Koerber, M. D.

Mar. 19 24 (Address) 1301 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 18 1924
20 UNDERTAKER	ADDRESS
Wendell Appel & Son	375 Hm

N. B.—WRITE PLAINLY. PHYSICIANS should state mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it ma TION is very important. See instructions on bac

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84899

CERTIFICATE OF DEATH.

164

D 84899

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. Rebecca Knotts

(a) Residence No. Preston Valley Hts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Stanislaus Knotts

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eliza Harding

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Little Sisters of the Poor

(Address)

15- MAR 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/15/24

17- I HEREBY CERTIFY, That I attended deceased from 3/10 19 24 to 3/15 1924

that I last saw h. alive on 3/14 1924

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D W Bernardotti M. D

3/15 1924 (Address) 914 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL. 3/17/24

20-UNDERTAKER, J A Moran

ADDRESS 2000 E Balto St

All information should be carefully supplied. AGE should be stated EXACTLY. Physician should write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84900

CERTIFICATE OF DEATH.

5 153 84900

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Abraham Zerick

(a) Residence No. 115 Aisquith Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Zerick

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 95 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15- MAR 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/16/24

17- I HEREBY CERTIFY, That I attended deceased from March 1st 1924 to March 16th 1924

that I last saw him alive on March 15th 1924

and that death occurred, on the date stated above, at 11.9 m.

The CAUSE OF DEATH* was as follows:

Cellulitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wanner M. D.

3-16, 1924 (Address) 30 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Hebrew Rosedale	3—17 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E. Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84901

CERTIFICATE OF DEATH.

5 129

D 84901

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Houseman

(a) Residence No. 115 Aisquith Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Houseman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 79 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Borel —

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jacob Houseman

(Address) 115 Aisquith St

15-

FILED MAR 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-16-24

17- I HEREBY CERTIFY, That I attended deceased from March 2nd 1924 to March 16th 1924

that I last saw h.. alive on .. 15th 1924

and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wisner M. D.

3-16-1924 (Address) 30 S. B'way

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL. 3/17 1924

20-UNDERTAKER, Jack Levis 1439 — ADDRESS E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH is clearly specified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. In plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D 84902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 84902

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2018 Keyser ST., 8 WARD)

2-FULL NAME Patient V Morton

(a) RESIDENCE NO. 2018 Keyser ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Burell Persons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mahala Kelly

(Address) 2018 Keyser St

MAR 17 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-1924

17 I HEREBY CERTIFY, That I attended deceased from 2/8/, 1924, to 3/13/, 1924, that I last saw h[illegible] alive on 3/13/, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

(duration) yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Gastric catarrh - age, a

(duration) yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jas C Robinson, M. D.

3/16/24 (Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cemetery Va	Mar 17 1924

20 UNDERTAKER: Wm. P. G. Elliott — ADDRESS 1726 Eastland

N. B.—MATHEMATICAL ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Antoniak

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00b 84903

D 84903

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1622 E. Pratt St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenie Antoniak

(a) Residence No. 1622 E. Pratt St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 30 1923

7-AGE. 1 yrs. 1 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Julian Antoniak

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Mary Swarka

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Julian Antoniak

(Address) 1622 E. Pratt St

15-

MAR 17 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 15/1924.

17- I HEREBY CERTIFY, That I attended deceased from Mch 10, 1924, to Mch 15, 1924, that I last saw h[illegible] alive on Mch 15, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

(Duration) 5 yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Bradwell, M. D.

, 19 (Address) 1917 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19- PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. Mch 17, 1924

20-UNDERTAKER. ADDRESS 1930 Eastern

F. H. Ozazenski

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to have CAUSE OF DEATH stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84904

CERTIFICATE OF DEATH

90 D 84904

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1327 Hanover St

CITY OF BALTIMORE: (No. Mary B. Kunz ST., 23 WARD)

2-FULL NAME .....

(a) RESIDENCE NO. 1322 Hanover ST., WARD 23
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander F Kunz

6 DATE OF BIRTH (month, day, and year): April 23rd 1837

7 AGE — Years: 84 — Months: 10 — Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Baumeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Hinkmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: John R. Kunz

(Address): 1322 Hanover St.

15 MAR 17 1924 16 ROBERT E. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 14 1924

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1924, to March 14, 1924, that I last saw her alive on March 14, 1924, and that death occurred, on the date stated above, at 11 20 P m.

The CAUSE OF DEATH* was as follows:

Decompensation of heart

Valvular Lesion

Cont. Sig. (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis & Nephritis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) C Kann, M. D.

3/15, 1924 (Address) 1214 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: March 17 1924

20 UNDERTAKER: E Schloman & Son — ADDRESS: 1539 Hanover

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84905

CERTIFICATE OF DEATH.

49 ✓

D 84905

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin R. Palmer

(a) RESIDENCE NO. 1801 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6/1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Clarence L. Palmer

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Carry M. Patton

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Clarence L. Palmer

(Address) 1801 Hanover

Filed MAR 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Mar 15, 1924

that I last saw him alive on Mar 14, 1924

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Kidney

about 4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epithelioma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell, M. D.

Mar 16, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Mar 18 1924
20 UNDERTAKER E. Schloman & Son	ADDRESS 539 Hanover

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 84906

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D 84906

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 512 S. Collington Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Centonia Semerad

(a) Residence No. 512 S. Collington Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Semerad

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS:

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

11- (Informant) Frank Semerad

(Address) 512 S. Collington Ave

15- Filed MAR 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 15/24

17- I HEREBY CERTIFY, That I attended deceased from Mar 2 19 24, to Mar 15 19 24

that I last saw h. alive on Mar 15 19.....

and that death occurred, on the date stated above, at 11.45A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

.....(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

.....(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M. Downes, M. D.

Mar 16 1924 (Address) 1228 N Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. Mar 18 1924

20-UNDERTAKER Frank Trautson — ADDRESS 1406 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84907 — 90 — D 84907

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. St. Agnes Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rika Heuer

(a) Residence No. 1911 Jefferson St. Ward

(Usual place of abode) (If non resident, give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: ~~Female~~

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Heuer

6-DATE OF BIRTH (month, day and year): Oct 11/64

7-AGE: 59 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Herman Heuer

(Address): 1911 Jefferson St

15- MAR 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 16-24

17- I HEREBY CERTIFY, That I attended deceased from March 1 19 24 to March 16 19 24

that I last saw h[illegible] alive on March 16 19 24

and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) — yrs 6 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S Goldman, M. D

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 3/20 19 24

20-UNDERTAKER: Philip Henry — ADDRESS 2016 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84908

CERTIFICATE OF DEATH.

90 D 84908

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2007 Cecil Ave ST 7 WARD)

2-FULL NAME J. Frederick Heim

(a) RESIDENCE NO. 424 S. Washington ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs 8 mos 2 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Elizabeth Heim

6 DATE OF BIRTH (month, day, and year) July 14/62

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer 034

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John M. Heim

(Address) 2007 Cecil Ave

15 Filed MAR 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16 1924 to March 16 1924.

that I last saw him alive on March 15, 1924,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Tabardus, disease of the Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. Bashwell, M. D.

, 19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 3/19 1924

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, with ink only. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84909

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3030 E. Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Aumiller

(a) Residence No. 3030 E. Monument St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Nicolas Aumiller

6-DATE OF BIRTH (month, day and year) Jan 9/62

7-AGE. 62 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) City

PARENTS.

10-NAME OF FATHER Felix Wetter

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Margaret

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md.

14- (Informant) Nicolas Aumiller

(Address) 3030 E. Monument

15- Filed MAR 17 1924, 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 15 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 9 1924 to Mar 15 1924

that I last saw her alive on Mar 15 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

1. Hepatic Cirrhosis Liver.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of — —

Was there an autopsy? — What test confirmed diagnosis? Physical Exam

(Signed) Geo E Lubby MD Cadell, M. D

3/16 1924 (Address) 143 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 3/19 1924

20-UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84910

CERTIFICATE OF DEATH.

D 84910

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 N. Patterson Pk Ave. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Helen Collenberg

(a) Residence No. 805 N. Pat. Pk. Ave St., Ward,

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 13/49

7-AGE. 74 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) City

PARENTS.

10-NAME OF FATHER, Christian Collenberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md 3

14- (Informant) Mrs Matilda Voelker

(Address) 805 N. Pat. Pk. Ave.

15-

Filed ... 192.. ROBERT F. KRAUTER, Registrar.

SEP 1 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/15/24

17- I HEREBY CERTIFY, That I attended deceased from 3-13 1924 to 3-15 1924

that I last saw h[illegible] alive on 3-15 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No findings

What test confirmed diagnosis?

(Signed) F. Fred Ryerson M. D.

3-16-1924 (Address) 806 N. Pat. Pk. Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL, 3/18 1924

20-UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84911

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., V Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E. Bragg

(a) Residence No. 307 S. Broadway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Octavia Bragg

6-DATE OF BIRTH (month, day and year) Sept 22/73

7-AGE. 50 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Richmond Va.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14- (Informant) Octavia Bragg

(Address) 307 S. B'way

15- MAR 17 1924 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/16/24

I HEREBY CERTIFY, That I attended deceased from Mch 11 19 24 to Mch 14 19 24

that I last saw h.. alive on Mch 14 19 24

and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

3/16/24 (Address) 2601 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal** or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn — DATE OF BURIAL. 3/17 1924

20-UNDERTAKER. Philip Hennig — ADDRESS 2016 Orleans St.

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84912

CERTIFICATE OF DEATH.

16 D 84912

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Lutheran District ap. Pres Pav. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Boehm

(a) Residence No. Preston & Tally Sts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, ~~or Divorced~~ Widower (Write the word.)

5a-~~If married, widowed, or divorced~~ ~~HUSBAND of (or) WIFE of~~ Louisa Manton

6-DATE OF BIRTH (month, day and year) 20 July 1841

7-AGE. 83 yrs. 7 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gold

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Germany (State or Country),

PARENTS.

10-NAME OF FATHER, Boehm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unk

12-MAIDEN NAME OF MOTHER, Rosina Schirmer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unk

14-

(Informant) Preston Florence

(Address) Preston & Tally Sts

15-

Filed 19

MAR 13 1924 Registrar.

Special Deputy Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/15-24

17- I HEREBY CERTIFY, That I attended deceased from 3/10 1924, to 3/15 1924

that I last saw him alive on 3/14 1924

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Elmer Wirth M. D

3/15 1924 (Address) 914 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL, Mar. 19, 1924

20-UNDERTAKER. H. C. Wiedefeld

ADDRESS 904 Greenmt Ave

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84913

CERTIFICATE OF DEATH.

90 D 84913

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 W. Hill ST., 7W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora E Carpenter

(a) RESIDENCE NO. 7 W Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of James H Carpenter

6 DATE OF BIRTH (month, day, and year) June 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Sussex Co (State or country) Del

PARENTS

10 NAME OF FATHER Thos B Wilson

11 BIRTHPLACE OF FATHER (city or town) Sussex Co (State or country) Del

12 MAIDEN NAME OF MOTHER Margaret Joseph

13 BIRTHPLACE OF MOTHER (city or town) Sussex Co (State or country) Del

14 Informant James H Carpenter (Address) 7 West Hill st

MAR 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923 to March 14 1924

that I last saw her alive on March 14 1924

and that death occurred, on the date stated above, at 2-15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Rheumatoid Arthritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Hall Pleasants M. D.

3/15 1924 (Address) 1 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Mar 18 1924
20 UNDERTAKER	ADDRESS
John H Denny	715 Light St

N. B.—MATTER PRINTED IN ITALICS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

D84914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D84914

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S - 16th St ST., 76 WARD)

2-FULL NAME Louisa M. Nicklas

(a) RESIDENCE NO. 519 S. 16th St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M Nicklas

6 DATE OF BIRTH (month, day, and year) May 12, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Germany died

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Jentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Habisreutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Annie L. Krauss 519 South 16th St

15 Filed MAR 17 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1924

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1924, to March 16, 1924, that I last saw her alive on March 16, 1924, and that death occurred, on the date stated above, at 4 30 P.m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical ex

(Signed) J. M. Lamperin, M. D.

19 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 3/19/24

20 UNDERTAKER Wm Cook

ADDRESS 501 E North Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

1001 Fulton Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84915

CERTIFICATE OF DEATH.

1729

D 84915

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1818 St Mount St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Patrick

(a) Residence No. 1818 St Mount St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, Never or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: George

6-DATE OF BIRTH (month, day and year): Aug 9 1849

7-AGE: 74 yrs. 7 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Woman

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): England

PARENTS.

10-NAME OF FATHER: Wm James

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Martha James

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14-

(Informant): George F. Finch

(Address): 1818 St Mount

15-

Filed MAR 17 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 23 19 24 to March 14 19 24 that I last saw h[illegible] alive on March 14 19 24 and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis

(Duration) 8 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Robt & Microscope

(Signed) J. Thomas Jenkins M. D

, 19 (Address) 1001 Fulton ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 17 1924

20-UNDERTAKER: Wm Cook & Son E Baltimore — ADDRESS

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84916

CERTIFICATE OF DEATH.

D 84916

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Light St., 24th WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Weber

(a) RESIDENCE No. 1813 Light St. ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. 11 mos. 1 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Weber

6 DATE OF BIRTH (month, day, and year) April 15, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know

14 Informant John Weber (Son)

(Address) 1813 Light St

15 Filed MAR 1 7 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16/24

17

I HEREBY CERTIFY, That I attended deceased from March 15 24, 19 ..., to March 16 24, 19 ...,

that I last saw h.. alive on March 16/24, 19 ...,

and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Paralysis (Hemiplegia)

Cerebral Hemorrage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hyp Blood Pressure

(duration) 5 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Howard Evans, M. D.

(Address) 1813 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL March 19/24

20 UNDERTAKER A. Howard Evans 1425 E. Chase St.

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84917

CERTIFICATE OF DEATH.

D 84917

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5010 Catalpha Rd ST. Lauraville 27 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella L. Wilhaine

(a) RESIDENCE No. 5010 Catalpha Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C Wilhaine

6 DATE OF BIRTH (month, day, and year) Oct 19 56

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	4	24	

8 OCCUPATION OF DECEASED housework & dressmaker 069

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James M. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Fannie Blanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Jno F Jones (Address) 5016 Catalpha Rd

15 Filed MAR 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 20, 1923, to Mar 14, 1924.

that I last saw her alive on Mar 14, 1924,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) general yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Block

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? manifestations

(Signed) H E Krug M. D.

3/16 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/17 1924
20 UNDERTAKER	ADDRESS
Jones & Toulson	12 N. Green

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84918

CERTIFICATE OF DEATH.

D 84918

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 235 N. Durham St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Jolly

(a) Residence No. 235 N. Durham St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James N. Jolly

6-DATE OF BIRTH (month, day and year) 2-10-1860

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or. mtn.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER Thomas Montague

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Lucy Montague

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) James W. Jolly

(Address) 235 N. Durham St

15- MAR 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-14-24

17- I HEREBY CERTIFY, That I attended deceased from March 12 1924 to March 14 1924 that I last saw h[er] alive on March 13 1924 and that death occurred, on the date stated above, at 1230 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis not known

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D

3-14 1924 (Address) 827 N Bond St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Laurel Cem	March 17 1924
20-UNDERTAKER	ADDRESS
Mrs J. G. Locke	1302 Jefferson

should be carefully supplied. AGE should be stated EXACTLY. INFORMATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Mullen

D 84919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84919

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., Mt. Ver. & W. Ward) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ellen M. Mullen

(a) Residence No. 4795 Reisterstown Rd., St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John B. Mullan

6-DATE OF BIRTH (month, day and year) Feb. 10th 1855

7-AGE. 69 yrs. 1 mos. 6 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Allen Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Elizabeth Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. Roby Stull

(Address) 4795 Reisterstown Road

15- MAR 17 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1924 to March 16 1924

that I last saw h. alive on March 16 1924

and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Goldeman M. D

, 19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. March 18. 1924

20-UNDERTAKER. Chas. W. Dill — ADDRESS 3109 Fredk. Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that CAUSE OF DEATH is correctly classified. Exact statement of OCCUPATION is very important. See if plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 84920

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 1206 N Montford Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos F. Smith

(a) Residence No. 1206 N Montford Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Married

3a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Lucy M Smith

6-DATE OF BIRTH (month, day and year): March 2 1853

7-AGE: 70 yrs. 11 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Patern do

(b) General nature of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ind

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-INFORMANT: Lucy M Smith

(Address): 1206 N Montford

15-

MAR 17 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 16 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924, to March 16 1924

that I last saw h[illegible] alive on March 16, 1924

and that death occurred, on the date stated above, at 1130 A. m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Endocarditis & Nephritis

(Duration) yrs. mos. 16 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Lyman, M. D.

3/17, 1924 (Address) 718 N Pat Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Ind

DATE OF BURIAL: March 19, 1924

UNDERTAKER: CHENOWETH & SON,

ADDRESS: 3617 CHESTNUT AVE.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84921

CERTIFICATE OF DEATH.

3/ D 84921

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1944 W. Pratt St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Nellie E Scannell

(a) Residence No. 1944 W. Pratt St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Scannell.

6-DATE OF BIRTH (month, day and year) Feb 28 1857

7-AGE. 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-DOCUMENTATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER. James Peack

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Sarah Baker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14 (Informant) Mrs. Scannell

(Address) 1944 W. Pratt St

15- Filed..... 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MAR 17 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 16/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924 to March 16, 1924

that I last saw her alive on March 16, 1924

and that death occurred, on the date stated above, at 9 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

6

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. C. Tubinser, M. D.

3/17, 19 (Address) 814 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Balto — DATE OF BURIAL. Mar 19 24

20-UNDERTAKER. Schenowerk & Son — ADDRESS 3615 Chestnut ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001 D 84922

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1002 Cathedral ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Melvin Moore

3a) RESIDENCE NO. 406 E. 31 ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 16 1903

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3 20	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto driver 0 x 3
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer — None

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER A. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Culp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Andrew J. Moore
Address 406 E 31st

15 Filed ..... 192 ..... Burial Permit Clerk,
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Poisoning due to Accident

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner.)

March, 1924 (Address) 1 E 39 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 3 days.

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Com	March 18 1924
20 UNDERTAKER	ADDRESS
Ehrenworth & Son	26 E Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D 84923

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Hess,

(a) Residence No. 1105 Poplar Grove St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If ~~married~~, widowed, or ~~divorced~~, HUSBAND of (or ~~WIFE of~~) Annie D. Hess

6-DATE OF BIRTH (month, day and year) Jan. 23. 1840

7-AGE: 84 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired 086

(b) General nature of Industry, business, or establishment in which employed (or employer): Pattern Maker

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Frederick Hess,

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant): Miss Amelia Hess

(Address): 1105 Poplar Grove St

15-Filed ..... 19.... ROBERT R. KRAUTER, Registrar.

MAR 17 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): MAR 15 1924

17- I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to Mar 15, 1924, that I last saw h~~im~~alive on March 15, 1924, and that death occurred, on the date stated above, at 11—P....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with gradual decompensation

.....(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

.....(Duration) (?) yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hawley Cole, M. D.

3/16, 1924 (Address) 2202 Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~, Loudon Park

DATE OF BURIAL, MAR 18 1924, 19....

20-UNDERTAKER, Geo W Little

ADDRESS 1230 EDMONDSON AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84924

CERTIFICATE OF DEATH.

D 84924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Linden Ave., ST. 14 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Crandall Bass

(Residence in Baltimore: No. 1513 Linden Ave., St.: 2 yrs. 11 mos. 24 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. August 31st, 1855 (Month) (Day) (Year)

7-AGE. 68 yrs. 6 mos. 17 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

9-BIRTHPLACE. (State or Country) Chelsea Mass

PARENTS.

10-NAME OF FATHER. — Bass

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Sarah J. [illegible] Peters

13-BIRTHPLACE OF MOTHER (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Bass Gandy

(Address) 1513 Linden Ave

15- MAR 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH March 17, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 27th 1922, to March 17th 1924, that I saw him alive on March 16th 1924, and that death occurred, on the date stated above, at 4.20 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis and Endocarditis

(Duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) yrs. 3 mos. da.

(Signed) J. B. Fleischauer M. D.

3/17, 1924 (Address) 1901 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....da. In the State ....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Concord Mass DATE OF BURIAL. MAR 17 1924

20-UNDERTAKER Geo N. Little ADDRESS 2730 EDMONDSON AVE.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84925

CERTIFICATE OF DEATH.

161-001

D 84925

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3850 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Sherwood.

(Residence in Baltimore: No. 3850 Falls Road St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~, (*Write* the word.)

6-DATE OF BIRTH, March (Month) 13 (Day), 1924 (Year).

7-AGE, ✓ ....yrs. ....mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City.

PARENTS.

10-NAME OF FATHER, John Everett Sherwood.

11-BIRTHPLACE OF FATHER (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER Rhoda Naomi Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Sherwood

(Address) 3850 Falls Road

15- MAR 17 1924

By ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 15 (Day), 1924 (Year).

17. I HEREBY CERTIFY, That I attended deceased from March 13 1924, to March 1924, that I saw h[illegible] alive on March 14 1924, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

Two months gestation

.....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) A. J. Davies M. D.

3-15, 1924. (Address) 800 W 33rd St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Gtrude Ridge — DATE OF BURIAL, March 17, 1924

20-UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Road

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 84926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 84926

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Karl

(a) RESIDENCE No. 2730 Dillon St. ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Mary C. Karl.

6 DATE OF BIRTH (month, day, and year) November 29, 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pipe fitter
(b) General nature of industry, business, or establishment in which employed (or employer): helper.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Karl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary G. Karl (wife). (Address) 2730 Dillon St.

15 Filed MAR 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acid burns about the body. Shock.
Accidental fall in Nitrous Acid tank.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt (Coroner) M. D.

March 16, 24 (Address) 1011 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Baltimore Copper & Smelting & Rolling Co.

~~Former residence~~ Accident March 14, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Ecm

DATE OF BURIAL: Mch 1924

20 UNDERTAKER: Lilly & Zuern

ADDRESS: 4000 W. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84927

CERTIFICATE OF DEATH.

90 D 84927

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Parkwood Av ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Abraham Jacobs

(Residence in Baltimore: No. 2907 Parkwood av St.; 38 yrs., ... mos. ..... da.)

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1860 (Year)

7-AGE, 64 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 045

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Zorach J. Jacobs

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Leah Glasner

13-BIRTHPLACE OF MOTHER (State or Country), Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Leurs

(Address) 1439 E Baltimore St

15-

MAR 17 1924

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924, to March 16 1924, that I saw h in alive on March 16 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 1 da.

CONTRIBUTORY (Secondary) Endocarditis Myocarditis arteriosclerosis

(Duration) 8 yrs. ..... mos. ..... da.

(Signed) Joseph Lichner M. D.

March 16 1924 (Address) 1526 Mashall St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Hebrew Rodef Sh | DATE OF BURIAL, 3-17-, 1924

20-UNDERTAKER Jack Leurs | ADDRESS 1439 E Balto St

Spec—12-23-21—E.B.R.S.—400 Blks.

84928

HEALTH DEPARTMENT—CITY OF BALTIMORE

84928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 632 N. Hilton st St., 16 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth Little

(a) Residence No. 632 N. Hilton St., 16 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ ~~Married~~ Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of late John A. Little

6-DATE OF BIRTH (month, day and year) Sept 3, 1863

7-AGE. 60 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Charles E. Lubury

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Georgiana Pindell

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

14-

(Informant) Miss Lillian Little

(Address) 632 N. Hilton st

MAR 17 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 5th 1924 to March 15 1924

that I last saw h.. alive on. March 15 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

Dementia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. 6 mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ....Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Guy Dorsey M. D.

3/16. 1924 (Address) 400 N. Parkson St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cemetery	March 19 1924
20-UNDERTAKER.	ADDRESS
Jos Sourdeno + Son	217 S. Paca st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should SIGN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 84929

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. White

(a) RESIDENCE NO. 2315 Jefferson St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 31/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	✓	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Dibbern

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Catherine Dibern White
(Address) 2315 Jefferson t

15 Filed MAR 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions-Probably central (brain lesion (Autopsy at Hebrew Hospital

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. H. Baer, M. D.
(Coroner.)

Mar 16/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mar 18 1924
20 UNDERTAKER	ADDRESS
Jas C. Miller	2334 Huffman St

REGISTRATION SHOULD BE CAREFULLY SUPPLIED. AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 84930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84930

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Traction St. 13 Ward)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Farrington

(Residence in Baltimore: No. 1408 Traction St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Abt (Month) (Day) 1890 (Year)

7-AGE, 34 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

9-BIRTHPLACE, (State or Country), Tenn.

PARENTS.

10-NAME OF FATHER, Robert Farrington

11-BIRTHPLACE OF FATHER (State or Country), Tenn.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia Thompson friend

(Address) 1408 Traction St.

15- MAR 17 1924 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 14, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1924, to Mch 14 1924, that I saw h m alive on Mch 14 1924, and that death occurred, on the date stated above, at 6P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H S McCleaf M. D.

3/16, 1924 (Address) 3001 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cemetery — DATE OF BURIAL, Mar. 17, 1924

20-UNDERTAKER J. W. M. Johnson — ADDRESS 1399 Druid Hill Ave.

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS, if under 1 year, and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Blks.

D 84931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84931

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1108 S. Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Keller

(a) Residence No. 1108 S. Robinson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Keller

6-DATE OF BIRTH (month, day and year) Jan. 22-1858

7-AGE,	If LESS than 1 day,
66 yrs. 1 mos. 21 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, John Goodwin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14-(Informant) Bertha Brown

(Address) 1103 S. Robinson St.

MAR 17 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 14-24

17- I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to Mar 14, 1924, that I last saw h.er alive on March 14, 1924, and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Duncan S. Titlow, M. D.

3/15/24 1924 (Address) 315 S. Highland Ave

State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Western	Mch 18 1924
20-UNDERTAKER,	ADDRESS
Zurkler & Zirkler	1139 Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84932

101-001

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Iona Terrace ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna S. Miller

(a) RESIDENCE NO. 2911 Iona Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter F. Miller

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Stevens

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary M. Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Miss Elizabeth Miller (Address) 2911 Iona Terrace

15 Received MAR 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 13, 1924.

that I last saw her alive on " 13, 1924

and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. L. Neer, M. D.

3/15/24 (Address) 408 S Pat Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mch. 17, 1924
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

170284 D 84933

CERTIFICATE OF DEATH.

117 D 84933

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME ~~Henry~~ Harvey. Fisher

(a) RESIDENCE No. 1155 Whatcoat St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louise Fisher

6 DATE OF BIRTH (month, day, and year) —1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer D3

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Agnes Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

MAR 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1924 to March 14, 1924.

that I last saw him alive on March 14, 1924,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Peritonitis - generalized

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of March 9th

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) [illegible], M. D.

, 19 (Address) J H Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3/18 1924
20 UNDERTAKER Samuel H Hawley	ADDRESS 1378

N. B.—WRITE PLAINLY, with unfading ink. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84934

CERTIFICATE OF DEATH.

D 84934
Registered No. .....

1-PLACE OF DEATH
City of BALTIMORE: (No.) Municipal Hospital St., 76 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Rollins

(a) Residence No. Glyndon Md St., ...Ward.....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed~~, or Divorced (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE. 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

11- (Informant) Hos. Record
(Address) .....

15- MAR 17 1924 ROBERT A. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-14-24

17- I HEREBY CERTIFY, That I attended deceased from March 5, 1924, to March 14, 1924, that I last saw him alive on March 14, 1924, and that death occurred, on the date stated above, at 8-15 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
.....
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Non-specific Elephantiasis of left extremity - R. leg (Duration) 6 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 3/14/24.

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Wm. J. Fulton M. D.
, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. 3/17/24, 19..

20-UNDERTAKER. Samuel Hemsley — ADDRESS 178 N Bond St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 84935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100 D 84935

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 238 Hazel (Curtis Bay) 1st 25 WARD.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Potchen

(a) RESIDENCE No. 238 Hazel St. Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25. 1924

7 AGE

Years	Months	Days	If LESS than 1 day ....hrs or ....min.
		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Curtis Bay Balto. Md.

PARENTS

10 NAME OF FATHER: John Potchen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.

12 MAIDEN NAME OF MOTHER: Anna Szychoch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: John Potchen

(Address): 238 Hazel St.

15 MAR 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 16 1924

17 I HEREBY CERTIFY That I attended deceased from Mar. 14 1924 to Mar 16 1924,

that I last saw him alive on Mar 16 1924,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan Wert, M. D.

Mar 17 1924 Address) 816 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. A.A. Co.

DATE OF BURIAL: March 17 1924

20 UNDERTAKER: Margaret D. Flynn

ADDRESS: 1422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 84936

CERTIFICATE OF DEATH.

B 84936

Registered No. .....

1-PLACE OF DEATH
City of BALTIMORE: (No.) 708 Park Ave St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Pinkerton Cushing Morris Resident

(a) Residence No. 708 Park Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? 86 yrs. 7 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Judge Thos. J. Morris

6-DATE OF BIRTH (month, day and year) July 27 1837

7-AGE 86 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country) Baltimore Maryland

PARENTS.
10-NAME OF FATHER Jos. Cushing Jr.
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Maryland
12-MAIDEN NAME OF MOTHER Anne McKenzie
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Maryland

14-(Informant) Mrs. Josephine C. Morris Daughter
(Address) 708 Park Ave

MAR 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-15-24.

17- I HEREBY CERTIFY, That I attended deceased from 10-14-23 1923, to 3-14 1924
that I last saw her alive on 3-14 1924
and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:
ARTERIOSCLEROSIS
HYPERTENSION
CEREBRAL HEMORRHAGE
(Duration) 10 + yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) John L. Jones, M. D.
19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL, Mar 17, 1924
20-UNDERTAKER J. BOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. North Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS. Exact statement of OCCUPATION is desired. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Delius

D 84937

CERTIFICATE OF DEATH.

100-001 ✓

D 84937

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Delius

(a) RESIDENCE No. 3025 Parish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed , 19 ROBERT R. KRAUTER, Registrar

MAR 17 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 1-22 1924 to 3-14 1924

that I last saw her alive on 3-13 1924,

and that death occurred, on the date stated above, at 6 10 a m.

The CAUSE OF DEATH* was as follows

Senile Detenation

Chronic dysentery Arthritis (Hypostatic)

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Drane, M. D.

3-14 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 17 1924

20 UNDERTAKER Harry H. Weitzel ADDRESS 1534 W. Lombard

N. B.—WHITE PAPER; WRITE PLAINLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84938

CERTIFICATE OF DEATH.

90 D 84938

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Worthan

(a) Residence No. 219 N Poplar St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. mos. ds. If LESS than 1 day hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N. Carolina

PARENTS.

10-NAME OF FATHER, Davis Worthan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N. Carolina

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. Carolina

14- (Informant) Municipal Hospital Records

(Address)

15- MAR 17 1924 [illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-13-24

17- I HEREBY CERTIFY, That I attended deceased from 2-27 1924 to 3-13 1924

that I last saw h~~im~~alive on 3-13 1924

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Myocardial degeneration

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Thomas M. D.

3-13-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cem 3-17-1924

20-UNDERTAKER Edward Carlson J. H. Penniman

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84939

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 84939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE, (No. 605 Greenwillow St., 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Simmons

(a) Residence No. 605 Greenwillow St., Ward .....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced. (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 31, 1922

7-AGE, 1 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Eris Simmons

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Charleston S. C.

12-MAIDEN NAME OF MOTHER, Emma Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D C

14- (Informant) Eris Simmons
(Address) 605 E. Greenmount Ave

15- MAR 17 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17 1924

17- I HEREBY CERTIFY, That I attended deceased from March 16 1924 to March 17 1924 that I last saw him alive on March 17 1924 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows

Broncho Pneumonia (Primary)

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. Cooley M. D.

19 (Address) 753 Belnord

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	3-17, 1924
20-UNDERTAKER, David Easton	ADDRESS 976 Penna Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84940

CERTIFICATE OF DEATH.

101-001 ✓ D 84940

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Fremont Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Caroline Reilly

(a) RESIDENCE NO. 522 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ordinary pen and ink. FULL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 21 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	5	3	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Lee Reilly

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Marie Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Caroline Marie Reilly (Address) 522 N. Fremont St.

Filed MAR 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 6 1924 to March 15 1924, that I last saw h alive on March 15 1924, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Scarletinal Endocarditis

(duration) — yrs. 1 mos. 26 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

3-15 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Mar 18 1924

20 UNDERTAKER W. M. Tucker & Sons

ADDRESS North & Pa

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84941

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 33

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Cook

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1888

7-AGE.	If LESS than 1 day.
36 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jackson Cook

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed Robert P. Harrison Registrar.

89 T 71824

Burial-Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-14-24

17- I HEREBY CERTIFY, That I attended deceased from 8-3, 1923, to 3-14, 1924

that I last saw her alive on 3-13, 1924

and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) Claude A. Dreas M. D.

3-14, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19...
20-UNDERTAKER,	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health,

Pat. Aug. 5, 1902

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary 6 X 70

CITY OF BALTIMORE: (No. N. Broadway St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mc Dowell, Miss Jane R

(a) RESIDENCE NO. Martinsburg, W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29th 1917

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg
(State or country) W. Va.

PARENTS

10 NAME OF FATHER Robt L. McDowell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna

12 MAIDEN NAME OF MOTHER M. F. McDowell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant R. L. McDowell
(Address) Martinsburg W. Va

15 Filed MAR 1 74074, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 16, 1924, to Mar 17, 1924,

that I last saw her alive on Mar 17, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Brain abscess.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Martinsburg, W. Va

Did an operation precede death? N.O. Date of

Was there an autopsy? YES

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1924 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsburg W. Va	March 7 19 24
20 UNDERTAKER Liston P. Fuscellaro	ADDRESS 26 E. Saint Paul

B.—WHITE PLAINLY, WITH INDELIBLE PENCIL. NAME should be stated EXACTLY. PHYSICIAN should mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84943

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 W Saratoga ST. 18 WARD)

2-FULL NAME Baby Girl Taylor

(a) RESIDENCE No. 1029 W. Saratoga ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Mar. 15th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ..19.. hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Victoria Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14

Informant .....
(Address)

MAR 17 1924 Robert P. Harrison, 19
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16th 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 15th, 1924, to Mar. 16th, 1924, that I last saw her alive on March 16th 1924, and that death occurred, on the date stated above, at 9.00 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity & Congenital atelectasis 36 hrs.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Louis T. Downey Jr., M. D.

3-16 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL MAR 17 1924

20 UNDERTAKER [redacted] Health, ADDRESS .....

[illegible] WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D 84944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84944

CERTIFICATE OF DEATH. X 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. Lafayette & John ST. 5 14 WARD)

2-FULL NAME Miss Anna C. Pfister

(a) RESIDENCE NO. Cedar ave. Relay, Md. ST., WARD Relay Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1867

7 AGE: Years 56 | Month 5 | Days 22 | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Reese Publicity Co. Howard & Fayette Sts. Washington, D.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Gottlieb Pfister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany —

12 MAIDEN NAME OF MOTHER Katerine Baumann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany —

14 Informant John W. Klier — (Husband) (Address) Relay, Md.

15 Filed MAR 17 1924, 19 Robert P. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1924, to March 16, 1924, that I last saw her alive on March 16, 1924, and that death occurred, on the date stated above, at 5:48 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Uremia —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydrops of gall bladder, Cholelithiasis, Chronic interstitial Nephritis — Bronchopneumonia — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 28, 1924,

Was there an autopsy? No —

What test confirmed diagnosis? Physical Exam. + Operation —

(Signed) J. Eglé Warfield Jr. M. D.

19 (Address) Wahuga's Hospital — (OVCV)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Mar. 19, 1924

20 UNDERTAKER: Geo. L. Cook — ADDRESS: 1003 N. Bals

Burial Permit Clerk

— WRITE PLAINLY, with ordinary pen and ink. Do not use lead pencil. All the items should be stated EXACTLY. PHYSICIANS should be careful to see that their certification should be carefully supplied. AGE should be stated in years, months and days. If LESS than one day, hours or minutes. NAME OF INFORMANT should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84945

101-001 D 84945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1311 Hillman ST., 9 WARD)

2-FULL NAME Elizabeth Toulan

(a) RESIDENCE NO. 1311 Hillman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Toulan

6 DATE OF BIRTH (month, day, and year) July 10-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant P. F. Burns

(Address) 1311 Hillman St

15 Filed MAR 17 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 4, 1924, to Mar 16, 1924.

that I last saw h.e alive on Mar 14, 1924.

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clynical Tests

(Signed) W. E. Preston M. D.

3 17 1924 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL March 19 1924

20 UNDERTAKER K. C. Windfeld — ADDRESS 914 Fremont Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.— 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84946 — 44 D 84946

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Wilkens Ave, ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Edward Patterson,

(a) RESIDENCE. No. Columbus, Ga. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Lucy B. Patterson

6 DATE OF BIRTH (month, day, and year) Dec. 21-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Automobile Sales

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Euchee, Ala.

PARENTS

10 NAME OF FATHER Albert E. Patterson, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER Lizzie Sparks

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant Lucy B. Patterson (wife)

(Address) 2500 Wilkens Ave.

15 Filed APR 17 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/24 19

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1924, to Mar 14 1924.

that I last saw him alive on Mar 14- 1924.

and that death occurred, on the date stated above, at 2.45 C m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pharynx

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) C Heller Henning M. D.

3/16 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbus, Ga.	MAR. 1924
20 UNDERTAKER	ADDRESS
S. Rome Offutt, Sr.	115 N. Harrison Sane

N. B.—WHILE PLAINLY WRITTEN WORDS are preferable to abbreviations, the latter may be used, but all must be stated EXACTLY. PHYSICIANS should be careful to see that every item of information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 84947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84947

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospt. ST.: 4 WARD) 161-00

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby girl Garrett

(Residence in Baltimore: No. Franklin Sq. Hospt. maby St.: ..... yrs., ... mos. ..... ds.)

731 W. Fayette St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	white	

6-DATE OF BIRTH, 3 (Month) 9 (Day) 24 (Year)

7-AGE, 0 yrs. 0 mos. 7 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Garrett

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Helen Forster

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Garrett

(Address) 731 W. Fayette st

15- Robert P. Harrison, 191 Registrar.

MAR 17 1924

Buried Forest Park Cem.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) - 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-9-1924 to 3-16-1924, that I saw her alive on 3-16-1924, and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Difficult Birth

Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Labor

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. W. Thomas M. D.

Mar. 17, 1924 (Address) 1728 Kennard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, 3-18, 1924.

20-UNDERTAKER Robert Brooks & Son ADDRESS Callhoun - Hollins

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is very CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 D 84948

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 S. Calhoun St. ST., 19 WARD)

2-FULL NAME Evaline V King

(a) RESIDENCE No. 219 S. Calhoun St. ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F King

6 DATE OF BIRTH (month, day, and year) June 19-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aa Co Md

PARENTS

10 NAME OF FATHER Richard Jeffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Aa Co Md

12 MAIDEN NAME OF MOTHER Nancy Hood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aa Co Md

14 Informant Wm F King

(Address) 219 S Calhoun St

15 Filed Robert P. Harrison, Registrar

R 71524

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16, 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1923, to March 16, 1924.

that I last saw her alive on March 16, 1924.

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (2yrs.)

Cerebral Hemorrhage

.....(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Uremia

.....(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coston M. D.

3/17, 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 3/19 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84949 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 84949

CERTIFICATE OF DEATH.

70

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Bernard M. Welsh

(a) Residence No..... 1120 Riverside ave. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 6. 1907

7-AGE,	If LESS than 1 day,
16 yrs. 8 mos. 16 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER, William J. Welsh

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Balto., Md.

12-MAIDEN NAME OF MOTHER, Mary M. McMahon

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Balto., Md.

14- (Informant)... William J. Welsh

(Address)..... 1120 Riverside ave.

15- Filed..... 19.. Robert P. Harrison Registrar.

AR 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/12/24

17- I HEREBY CERTIFY, That I attended deceased from 2/20/24 19..... to 3/12/24 19.....

that I last saw h[illegible]ive on 3/4/24 19.....

and that death occurred, on the date stated above, at 2 11 M.

The CAUSE OF DEATH* was as follows:

Probable Brain Abscess

?

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs..... mos..... ds.

18-Where was disease contracted if not at place of death? ? 2/25/24

Did an operation precede death? Yes Date of Jan 30

Was there an autopsy? None allowed

What test confirmed diagnosis? Clinical

(Signed)..... H. W. Steele M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Cathedral Cem.	March 20. 1924
20-UNDERTAKER,	ADDRESS
Margaret L. Flynn	1422 Light St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 84950

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospl ST., 6 WARD)

REGISTERED NO. 141

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Ritter.

(a) RESIDENCE NO. 1339 N Belnord Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Jos Ritter

6 DATE OF BIRTH (month, day, and year) Dec. 2 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hurje 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Jos Hornic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Marie Mrnus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Eliz. Ritter

(Address) 133 N. Broadway

15 Filed MAR 17 1924 19.. Robert P. Harrison, Registrar

Burial Permit Gen.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-24

17 I HEREBY CERTIFY, That I attended deceased from 3-11-24, 19.., to 3-16-24, 19.., that I last saw her alive on 3-16-24, 19.., and that death occurred, on the date stated above, at 1.25 P m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Uterine Procidentia. 17 yrs.

Cardiac insufficiency yrs. mos. 3 hrs.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? 3/12/24 Nature of Pro

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Md Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Mar 18 19 24
20 UNDERTAKER	ADDRESS
Leo G. Cook	North & Hanford Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17004 Surg 84951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84-957

D 84951

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mary King

(a) RESIDENCE NO 24 Cathedral St Annapolis Md ST., 4 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 22 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. W. King

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Marcellus Collect

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL.

15 MAR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1924, to March 17, 1924, that I last saw her alive on March 17 1924, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Carcinoma of Pancreas

(duration) 2-3 months yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus ?

(duration) ..... yrs. ..... mos ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of about March 2 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Section

(Signed) J. Walter Sa ..... M. D.

19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md.

DATE OF BURIAL 3/20 1924

20 UNDERTAKER Joseph T. Hornsby

ADDRESS Annapolis Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 V

D 84952

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 203 Tramore Rd. Hamilton 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Frances Talley

(a) Residence No. 607 S. Linwood Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: William Talley

6-DATE OF BIRTH (month, day and year): June 11-1862

7-AGE: 61 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Henry Boyce

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Minnie Swoook

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) William Talley

(Address) 607 S. Linwood Ave

15- MAR 18 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar. 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from 3/3 19 24 to 3/15 19 24

that I last saw her alive on 3/14 19 24

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) 3 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Leifschneider M. D.

3/15, 1924 (Address) 19 E. Eager Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
First Evangelical Cemetery	Mar. 18, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander's Sons	1710 Fleet St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Sarah R. Burgan.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84953

CERTIFICATE OF DEATH.

D 84953

REGISTERED NO.

1-PLACE OF DEATH Church Home-Infirmary

CITY OF BALTIMORE: (No. 1 N Broadway ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burgan. Sarah R. Mrs

(a) RESIDENCE NO. 1405 Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Burgan

6 DATE OF BIRTH (month, day, and year) April 11-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particulsr kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Falkner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry Burgan

(Address) 6621 Limerick Ave

MAR 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1916 to Mar 16, 1924,

that I last saw her alive on Mar 16, 1924,

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(due to enterolith)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Complete anuria

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1405 Ellwood Ave. City

Did an operation precede death? No Date of Mar 16. 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Lesley A. Pelrath M. D.

2/16 1924 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Mar 19 1924
20 UNDERTAKER	ADDRESS
H. Vander & Sons	710 Flat St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully supplied. so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Bertha B. Turner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84954

CERTIFICATE OF DEATH.

38 D 84954

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1626-W. Mulberry ST., 19 WARD)

2-FULL NAME Bertha Ray Turner

(a) RESIDENCE No 1626-W-Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓		8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William W. Mumley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Essie B. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westmoreland Co. Va

14 Informant (Address) Bertha B. Turner 1626-W-Mulberry

15 Filed MAR 18 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1924

17

I HEREBY CERTIFY, That I attended deceased from 3/14, 1924, to 3/16, 1924.

that I last saw her alive on 3/16, 1924.

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

~~Syphilis~~

Syphilis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Sy

(Signed) W. J. Godfrey, M. D.

, 19 (Address) 1626 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 19 24
20 UNDERTAKER Brown & Freeland	ADDRESS 1147 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This Certificate, when completed, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84955

D 84955

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 - Pennington Ave ST., 25 WARD)

2-FULL NAME Tekla Wiflint

(a) RESIDENCE NO. 1112 - Pennington Ave ST., 25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Barthalmew Wiflint.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Lithuania.

PARENTS

10 NAME OF FATHER Anthony Wiflint.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania.

12 MAIDEN NAME OF MOTHER Orschella Kriste

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania.

14 Informant Tekla Wiflint.

(Address) 1112 - Pennington ave

15 MAR 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1924, to Mar. 16, 1924,

that I last saw her alive on Mar. 13th, 1924,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia — a

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William H. Voth, M. D.

. 19 (Address) 816 - Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a. a.	March 19 1924
20 UNDERTAKER	ADDRESS
John Grabliauckas	425 S. Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very Important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Unger.

D 84956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 84956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 N. Broadway St. 6 ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Unger.

(Residence in Baltimore: No. 23 N. Broadway ave St.; yrs. 70 mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. June 17th, 1854 (Month) (Day) (Year)

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Edwin Berry.

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Mary Lieb

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Finely

(Address) 23 N. Broadway ave

15- Filed MAR 18 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 15, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 14 1923, to March 15 1924, that I saw h[illegible] alive on March 15 1924, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Uteris

(Duration) yrs. 10 mos. 1 ds.

(Signed) Louis U. Gundrum M. D.

3/17 1924 (Address) 1616 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery

DATE OF BURIAL, Mar. 19th, 1924.

20-UNDERTAKER Johannah Nanolos

ADDRESS 1004 Aisquith st

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84957

CERTIFICATE OF DEATH.

44

D 84957

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1264 Glyndon Ave ST., 21 WARD)

2-FULL NAME Ernest W. Rehrenberg

(a) RESIDENCE NO. 1264 Glyndon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rehrenberg

6 DATE OF BIRTH (month, day, and year) Nov. 11. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Estimate Maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Leuchting Bot. Factory

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Rehrenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elenora Father

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Rehrenberg (Address) 1264 Glyndon Ave

15 Filed MAR 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 16. 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1924, to March 16, 1924.

that I last saw h— alive on March 13, 1924

and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Glands

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 34 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Cemetery — DATE OF BURIAL March 18, 1924

20 UNDERTAKER [illegible] ADDRESS Mrs John H. Leupel & Son 804 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE al CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

AGE should be stated EXACTLY. PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPA- s on back of certificates.

Spec—12-23-21—E.B.K.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

) 84958

CERTIFICATE OF DEATH.

17 D 84958

1-PLACE OF DEATH Eutaw Place & Brooks Lane Registered No.....

City of BALTIMORE: (No. Cylburn Apts. 1B. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva R. Myers

(a) Residence No. Cylburn Apts. 1B. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of David Myers.

6-DATE OF BIRTH (month, day and year) Oct. 2, 1866.

7-AGE. 57 yrs. 5 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

37

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.
10-NAME OF FATHER. Elkan Ries
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany
12-MAIDEN NAME OF MOTHER. Bertha Weil
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mr. David Myers
(Address) Cylburn Apts. 1B.

15- Filed MAR 18 1924 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/17/24

17- I HEREBY CERTIFY, That I attended deceased from March 10 1924 to March 17 1924
that I last saw her alive on March 17 1924
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis : uraemia
(Duration) 14 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D
March 18, 1924 (Address) 1207 Eutaw Place.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL. 3/19/24 19....

20-UNDERTAKER. David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84959

CERTIFICATE OF DEATH.

89 D 84959

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 N Broadway ST., 8 WARD)

2-FULL NAME Mary E Sawyer

(a) RESIDENCE NO. 1416 N Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Edward H Sawyer

6 DATE OF BIRTH (month, day, and year) Dec 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath
(State or country) Maine

PARENTS

10 NAME OF FATHER Ira Mason

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maine

12 MAIDEN NAME OF MOTHER Ellen Trull

13 BIRTHPLACE OF MOTHER (city or town) Bath
(State or country) Maine

14 Informant Edward H Sawyer
(Address) 1416 N Broadway

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar
MAR 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1924, to Mar. 15, 1924, that I last saw her alive on March 15, 1924 and that death occurred, on the date stated above, at 1245a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Hypertension

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edgar P. Sandrock M. D.

, 19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bath Maine	Mar 17th 1924
20 UNDERTAKER George Schilling & Sons	ADDRESS 126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

D 84960

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 226 W. Madison 11 ST.; WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Katharine Murray Courtney

(Residence in Baltimore: No. 226 W Madison St St.; 51 yrs. 8 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Widow

6 DATE OF BIRTH: July 29th, 1873 (Month) (Day) (Year)

7 AGE: 51 yrs. 8 mos. 16 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Sales Lady
(b) General nature of industry, business, or establishment in which employed (or employer): Millinery

9 BIRTHPLACE (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Hubert Murray

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Anna Murray

13 BIRTHPLACE OF MOTHER (State or country): Unknown Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. C. Courtney

(Address) 226 W Madison

15. MAR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 16th, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January, 1923, to March 16th 1924, that I saw h.r. alive on March 16th, 1924, and that death occurred, on the date stated above, at 4.55 p m.

The CAUSE OF DEATH* was as follows:

CANCER of BLADDER

(Duration) 1 yrs. 2 mos. 16 ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas L Shearer M. D.

March 17th, 1924. (Address) 905 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Peters County	Mar 19, 1924

20 UNDERTAKER: A M Walker & Son — ADDRESS: Fremont & Lafayette Ave

FILMED

Cor.—1-12-23—M&T—100 Bks.

D 84961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

16 D 84961

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Wilcox St ST., 10 WARD)

2-FULL NAME Charles Wittich

(a) RESIDENCE NO. 1115 Wilcox St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth A. Wittich

6 DATE OF BIRTH (month, day, and year) June 2[illegible]/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Draftsman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles Wittich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Miss Kahler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth A. Wittich
(Address) 1115 Wilcox St

15 MAR 18 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17/192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphixiation
(Suicide)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cancer rectum (duration) 1 1/2 [illegible] mos. ..... ds.

(Signed) J. S. Waller, M. D.
(Coroner.)

Mar 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cemetery	March 20 192[illegible]
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

D 84962

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Hare ST., 6 WARD)

2-FULL NAME Elenora Dennison

(a) RESIDENCE NO. 112 N. Hare ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Dennison

6 DATE OF BIRTH (month, day, and year) Oct. 31 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Kerner

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Kahler

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Miss Amelia C. Kerner

(Address) 1517 W. Fayette St.

15 Filed MAR 18 1924 ROBERT F. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1924, to Mar 16, 1924, that I last saw h[er] alive on Mar 15, 1924, and that death occurred, on the date stated above, at 7.43 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Diabetes mellitus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine & Clinical

(Signed) H. M. Bracken, M. D.

Mar 21 1924 (Address) 1258 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Mar 18 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84963

CERTIFICATE OF DEATH.

181-00 D 84963

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 S. Sharp St. ST., 22 WARD)

2-FULL NAME Phillip E. Tress.

(a) **RESIDENCE NO** 428 S. Sharp St. **WARD**

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Carrie Tress

6 DATE OF BIRTH (month, day, and year) January 23, 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Wood worker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Phillip H. Tress

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mary Tress (sister)
(Address) 828 Inwood St Pittsburg, Pa.

15 Filed MAR 18 1924 ROBERT R. KRAUTER Register
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas asphyxia.
Accidental Death.

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

(Signed) Otto R. Reinhardt M. D. (Coroner.)

March 18, 192 4. (Address) 1014 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs. ....mos. ....ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa via B & O.

UNDERTAKER John F Denny

DATE OF BURIAL Mar 18 1924

ADDRESS 715 Light St

S. & S. 5441 H.P. Co.—1000 Bks.

D 84964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 84964

1-PLACE OF DEATH

CITY OF BALTIMORE (No 4809 Ferndale Ave ST 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter M Nyce

(a) RESIDENCE NO 4809 Ferndale Ave ST..... WARD.....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mes. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1874

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob R Nyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Elizabeth Nyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Henry H. Marsten

(Address) 1323 Madison Ave

15 Filed MAR 18 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923 to March 16, 1924, that I last saw h. alive on March 16, 1924, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Anamnesis

(Signed) A. C. Smith, M. D.

(Address) 4809 Ferndale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 19 1924
20 UNDERTAKER Chas. E. Joseph	ADDRESS 501 Madison ave.

N. B.—WHITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84965

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N Chapel ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Hall

(a) RESIDENCE No 1812 N Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John C Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lily Pistel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) John J Hall 1812 N Chapel St

15 MAR 18 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14th 1924 to March 17th 1924.

that I last saw h alive on March 15th 1924

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. One mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2nd mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signature) Jos Sloan, M. D.

(Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 18 1924
20 UNDERTAKER	ADDRESS
Geo M Frink & Son	811 N Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 84966

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

D 84966

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3000 N. North ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Selkow

(Residence in Baltimore: No. 3000 W. north ave. St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S

6-DATE OF BIRTH, April (Month) 1st (Day), 1914 (Year)

7-AGE, 9 yrs. 11 mos. 17 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER William Selkow

11-BIRTHPLACE OF FATHER (State or Country) Russia

12-MAIDEN NAME OF MOTHER Fannie Goldstein

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Selkow

(Address) 3000 N. North ave

15- MAR 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 17th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 15th 1924, to March 17th 1924, that I saw h[illegible] alive on March 14th 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry J. Faulkner M. D.

3/17th, 1924 (Address) 1192 Miller

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Kehran Washington Co

DATE OF BURIAL, 3-18, 1924

20-UNDERTAKER Jack Leubs

ADDRESS 1439 Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec[illegible] H. P. Co.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84967

D 84967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklyn Sq Hospital St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola K Simmons Lola. S. Va

(a) RESIDENCE No. 3615 Forest Park ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard K Simmons

6 DATE OF BIRTH (month, day, and year) Oct 3 1857

7 AGE Years 66 Months 5 Days 4 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Gloucester Co Va

PARENTS

10 NAME OF FATHER [illegible] Tragle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Tisdale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Leonard K Simmons (Address) 3615 Forest Park

15 Filed MAR 18 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1924, to March 17, 1924, that I last saw h[illegible] alive on March 17, 1924 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J A Mulligan M. D

19 (Address) 1303 W North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	May 19 192
21 UNDERTAKER W. J. Leidner & Sons	ADDRESS North

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84968

CERTIFICATE OF DEATH.

74-001 D 84968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S. Chapel ST. 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B. Ciesliak (Mary B. Ciesliak)

(a) RESIDENCE NO. 310 S. Chapel ST. ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michal Labzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Barbara Lesny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mr. William Ciesliak
(Address) 310 S. Chapel

MAR 18 1924

ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) ... yrs. ... mos. ... ds.

(Signed) Geo. Clinton Black, M. D. (Coroner)

3/18/24, 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	March 20 1924

20 UNDERTAKER ADDRESS

John M. Weber 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84969

CERTIFICATE OF DEATH.

65-001 ✓ D 84969

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Katz

(a) RESIDENCE No. 25 Lloyd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Singel.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4/1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20 Yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Frank Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Greenspun

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Harry Katz

(Address): 25 Lloyd St.

15 Filed MAR 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1924

17

I HEREBY CERTIFY, That I attended deceased from 3/16, 19 24 to 3/17, 19 24

that I last saw him alive on 3/17, 19 24

and that death occurred, on the date stated above, at 11:25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 1 hr

CONTRIBUTORY (Secondary) Acute Myeloid Leukemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Isidore S. Fry, M. D.

Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

DATE OF BURIAL: March 18 1924

20 UNDERTAKER: S Furman Bro

ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84970

CERTIFICATE OF DEATH.

98 D 84970

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 1 WARD)

2-FULL NAME Melvin Klein

(a) RESIDENCE No. 3003 O'Donnell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of nnone

6 DATE OF BIRTH (month, day, and year) May 19 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓		10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Kline

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Rose Makofsky

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Joseph Kline
(Address) 3003 O'Donnell St

Filed MAR 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Laryngitis (Non diphtheritic culture made by DR. Goldberg also by Hopkins.)

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Falcon, M. D.
(Coroner.)

Mar 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL March 18 1924

20 UNDERTAKER J. Levinson Bro — ADDRESS 112 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Hicklein

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 ✓

D 84971

D 84971 (13231)

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Lafayette Av ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Hicklein

(a) RESIDENCE No. 1323 Lafayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced (or) WIFE of John W. Hickman

6 DATE OF BIRTH (month, day, and year) Jan 12 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Nelson Born

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Evelyn Coats

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John W. Hicklein

(Address) 1323 Lafayette Ave

15 MAR 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1924

17 I HEREBY CERTIFY, That I attended deceased from March 7— 1924 to March 16 1924

that I last saw h[illegible] alive on March 16 1924

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Influenza

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Coleman M. D.

(Address) 2039 McCulloh

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL March 18 1924

20 UNDERTAKER Chas. H. Chase & Son

ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84972

CERTIFICATE OF DEATH.

100-001 ✓

D 84972
Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Handy

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-Single, Married, Single Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1861

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md
(State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ?
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ?
(State or Country),

14- (Informant) Municipal Hospital Records
(Address).....

15- MAR 18 1924 ROBERT R. KRAUTER, Commissioner of Health.
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-15-24

17- I HEREBY CERTIFY, That I attended deceased from 3-13, 1924 to 3-15, 1924 that I last saw him alive on 3-15, 1924 and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Senile Detioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Ext.

(Signed) Claude B. Hunt, M. D.

3-17, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, MAR 18 1924, 19....

20-UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

90

UNIVERSITY OF MARYLAND

1248

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84973 CERTIFICATE OF DEATH. 100-001 D 84973

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rogers

(a) Residence No. 1007 N. Dunbar St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1851

7-AGE, 73 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 18 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

1:247

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-15-24

17- I HEREBY CERTIFY, That I attended deceased from 3-14, 1924 to 3-15, 1924 that I last saw her alive on 3-15, 1924 and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude J. Orme, M. D.

3-17, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, 19

20-UNDERTAKER, ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND MAR 18 1924

ENG. AM. E. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84974

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1305 S Clinton St., 16 Ward) 90 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sanford H. Shaw

(a) Residence No. 1305 S. Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. S. Shaw

6-DATE OF BIRTH (month, day and year) July 22 1856

7-AGE, 68 yrs. 0 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ill.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), U-S-

14- (Informant) Martha S Shaw

(Address) 1305 S Clinton

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

MAR 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 30, 1924, to March 16, 1924, that I last saw h... alive on March 15, 1924, and that death occurred, on the date stated above, at 2401 m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy M. D.

3/17, 1924 (Address) 839 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL, 3/19 1924

20-UNDERTAKER Wm Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84975 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1515 N. Bethel St

CITY OF BALTIMORE: (No. 1515 N. Bethel ST., 8 WARD)

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie M Horton

(a) RESIDENCE NO. 1515 North Bethel ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George C Horton

6 DATE OF BIRTH (month, day, and year) Sept 23 1875

7 AGE Years 48 Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norwich, Conn.

PARENTS

10 NAME OF FATHER William Alden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norwich, Conn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Husband) (Address) 1515 N. Bethel St

15 Filed MAR 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1924, to Mar 16, 1924, that I last saw her alive on Mar 16, 1924, and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine?

(Signed) C. C. Macdonald, M. D.

Mar 16, 1924 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 19 1924

20 UNDERTAKER Jas Cook — ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 84976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 84976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Lindsay St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carter B. Clark

(a) RESIDENCE NO. 1005 Lindsay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Clark

6 DATE OF BIRTH (month, day, and year) about 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O&O
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Arthur Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Walter Clark

(Address) 813 E. Ft. Avenue Point

15 Filed MAR 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

cause yet to be ascertained 1.

Will file in later.

acute alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) yrs. mos. ds.

(Signed) H. C. Hennessy, M. D.

(Coroner)

March 15 1924 (Address) 202 Courthouse

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prince Edward Va.	March 18 1924

20 UNDERTAKER Mrs R. C. Elliott ADDRESS 1725 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84977

D 84977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 11 WARD)

2-FULL NAME AUGUST Schneider

(a) RESIDENCE NO. 1317 North Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Johanna Schneider

6 DATE OF BIRTH (month, day, and year) Nov 5/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Restaurant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER George Schneider

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Johanna Schneider
(Address) 1317 N. Charles St

15 Filed MAR 18 1924 192 Robert F. Duncan,
Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Heart Block due to possible pulmonary infarct.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis possibly tuberculosis (duration)) yrs. mos. ds.

(Signed) J. S. Wallace, M. D.
(Coroner.)

Mar 18/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park | DATE OF BURIAL Mch. 20 1924

20 UNDERTAKER Wm Cole | ADDRESS 502 E. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 84978

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 ✓ B 84978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 50 Darley Apts 2 C 15 ST., WARD)

2-FULL NAME James Bracken.

(a) RESIDENCE NO. 1635 Westwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5.	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Francis Bracken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Bracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Francis Bracken

(Address) 1635 Westwood

Filed MAR 18 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 18, 1924, that I last saw h— alive on March 18, 1924, and that death occurred, on the date stated above, at 5.8 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Sa Scheuerman M. D.

19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 24 1924

20 UNDERTAKER Wm Cook 502 E Ave

ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21—E.B.R.S.—400 Bks.

D 84979

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 84979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dolly Butler

(a) Residence No. 1719 W. Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1901

7-AGE. 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Georgia

PARENTS.

10-NAME OF FATHER. James Washington

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Georgia

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Georgia

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, Registrar.

MAR 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-16-24

17- I HEREBY CERTIFY, That I attended deceased from 2-14 1924 to 3-16 1924, that I last saw h~~e~~r alive on 3-16 1924, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

Mitral Stenosis and

Pulmonary Congestion

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Emphysema (Post-mortem)

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Uhrig M. D.

3-16, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	3/20/24
20-UNDERTAKER	ADDRESS
A. L. Gross	1440 McElderry

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 84980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. 2709 N Fairmount Ave St., 40 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara J. Taylor

(a) Residence No. 2709 N Fairmount St., Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John H Taylor

6-DATE OF BIRTH (month, day and year) 2-20-1847

7-AGE. 76 yrs. 0 mos. 22 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER. Wm Rogers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- (Informant) Mrs. Roland Coon

(Address) 2709 N Fairmount Ave

15- Robert P. Harris M.D. Registrar.

MAR 18 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-16-24

17- I HEREBY CERTIFY, That I attended deceased from Mar 10 1924 to Mar 16 1924 that I last saw h alive on Mar 16 1924 and that death occurred, on the date stated above, at 135A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Roland Coon M. D.

3/18, 1924 (Address) 1 W Randall Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem

DATE OF BURIAL. 3-19th, 1924

20-UNDERTAKER. Mrs Chas A G Rohde

ADDRESS 200 N Arlington Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Bowen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84981

CERTIFICATE OF DEATH.

X 118-002 ✓

D 84981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Gun Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Florence Bowen.

(a) RESIDENCE NO. Laurel ST., WARD Laurel Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H. Bowen

6 DATE OF BIRTH (month, day, and year) Jan 18 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England England

PARENTS

10 NAME OF FATHER John Gray.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Ellen Ellis.

13 BIRTHPLACE OF MOTHER (City or town) (State or country) England

14 Informant Frank H Bowen.

(Address) Laurel Md.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

APR 18 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.18.24

17 I HEREBY CERTIFY, That I attended deceased from 3.16.24 19 ..., to 3.18.24 19 ...,

that I last saw her alive on 3-18 '24

and that death occurred, on the date stated above, at 10.27 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial accident.

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cancer of Liver ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date 3/16/24 Time 7 a.m.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Mt Sinai Hosp'l

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Hebrew Friendship Natural Cem. Baltimore Co. Md. DATE OF BURIAL 3-21 1924

20 UNDERTAKER Ehrlich Harle ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 34982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 34982

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Annapolis ave ST., 25 WARD)

2-FULL NAME Elizabeth Seises

(a) RESIDENCE NO. annapolis ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Seises

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE Years 82 Months Days If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER David Levi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Chew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary L. Talbert

(Address) Mt Winans

15 Filed MAR 18 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-1924

17 I HEREBY CERTIFY, That I attended deceased from 3-10-1924 to 3-16-1924,

that I last saw her alive on 3-16-1924,

and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

angina Pectoris

arteriosclerosis

Valvular Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W B Hall, M. D.

, 19 (Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 3-19-1924

20 UNDERTAKER David Easton — ADDRESS 916 Pa ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 84983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 84983

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST., 8 WARD)

2-FULL NAME Kelton Pitts

(a) RESIDENCE No. 1207 Dallas St. E. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Antonia Pitts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Lizzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 MAR 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 16, 1924, that I last saw him alive on March 16, 1924, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Primary Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Meningitis, Pneumococcus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Above

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Casper Jones, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	March 19 1924

20 UNDERTAKER Mrs J. G. Locks ADDRESS 1302 Jefferson

Spec.—1-10 21 M&T 1500 Blks.

D 84984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 84984

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital, Bulkeley St., 11 WARD)

2-FULL NAME Miss Mary Catherine Morton

(a) RESIDENCE NO. 923 Cathedral St. Balto. Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
about	75			

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince Frederick Calvert County

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Edward Morton

11 BIRTHPLACE OF FATHER (city or town) Prince Frederick Calvert County

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. McPherson

13 BIRTHPLACE OF MOTHER (city or town) Prince George County

(State or country) Maryland

14 Informant Mr. Philander Briscoe

(Address) Fidelity Building

15 Filed MAR 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1924.

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 17, 1924, that I last saw her alive on March 17, 1924, and that death occurred, on the date stated above, at 11.00 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) G. T. Goff M.D. M. D.

3-18 1924 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prince Frederick Calvert Co. Md.	Mar 19 1924

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Calhoun St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84985 HEALTH DEPARTMENT—CITY OF BALTIMORE D 84985

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 665 W. Fayette Street St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherina Chandler

(a) Residence No. 665 W. Fayette Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Chandler

6-DATE OF BIRTH (month, day and year): 1866

7-AGE: 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: John Wohlfardh

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-

(Informant): Mrs. May Gamble

(Address): 132 N. Milton St.

MAR 19 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to March 17 1924 that I last saw her alive on March 15 1924 and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) About 18 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry E. Ade, M. D.

3-18, 1924 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. DATE OF BURIAL, Mar 20, 1924

20-UNDERTAKER: Joseph L. B. Cook ADDRESS 1003 N. Calvert St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 84986

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84986

CERTIFICATE OF DEATH.

91-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1647 Wilkens Avenue St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin F. Warthen

(a) Residence No. 1647 Wilkens Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie L. Warthen

6-DATE OF BIRTH (month, day and year) June 18, 1856

7-AGE. 67 yrs. 8 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Minister

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Horace Warthen

11-BIRTHPLACE OF FATHER (city or town) Montgomery County. (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Augusta Morrison

13-BIRTHPLACE OF MOTHER (city or town) Harford County (State or Country), Maryland

14- (Informant) Mrs. Minnie L. Warthen

(Address) 1647 Wilkens Ave.

15- Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 16, 19 24 to March 17, 1924

that I last saw him alive on March 17, 1924

and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Cockeluss M. D.

3-18. 1924 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. DATE OF BURIAL, Mar. 20, 1924

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84987

CERTIFICATE OF DEATH.

129

D 84987

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3610 Clifton Ave St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia E. Price

(a) Residence No. 3610 Clifton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) June 17. 1847

7-AGE. 77 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Ephraim Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Eliza R. Pickett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Edna B. Beck

(Address) 3610 Clifton Ave

15- MAR 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 17. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1923 to March 17. 1924.

That I last saw her alive on March 17 1924.

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis Hyperplastic and Paralysis

(Duration) 2 yrs. 1 mos. 17 ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(Duration) yrs. 1 mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum Exam

(Signed) Herbert C. Geppert, M. D.

March 18 1924 (Address) 3048 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount DATE OF BURIAL. March 19. 1924

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84988

CERTIFICATE OF DEATH.

31 D 84988

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1940 W. Franklin ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Bartholome, Jr

(a) RESIDENCE NO. 2014 Westwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alberta Marie Bartholome

6 DATE OF BIRTH (month, day, and year) April 21st 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	10	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer.

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer Independent Beef Co.

9 BIRTHPLACE (city or town) Harrisonville (State or country) Ind.

PARENTS

10 NAME OF FATHER Lewis Bartholome

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Baker

13 BIRTHPLACE OF MOTHER (city or town) Harrisonville (State or country) Ind.

14 Informant Martha Bartholome (Address) 1940 W. Franklin St.

15 Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18-1924.

17 I HEREBY CERTIFY, That I attended deceased from March 7. , 1924. to March 18- , 1924.

that I last saw him alive on March 17- , 1924.,

and that death occurred, on the date stated above, at 9:20. a. m.

The CAUSE OF DEATH* was as follows:

Influenzal Pericarditis

(duration) — yrs. — mos 17 ds.

CONTRIBUTORY (Secondary) Influenzal Pleurisy

(duration) — yrs. — mos. 24 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs

(Signed) Chester Riland, M. D.

3-18. 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 21 1924
20 UNDERTAKER Josiah Lyle	ADDRESS 1606 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

84989

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Loney)

CERTIFICATE OF DEATH.

111,002

D 84989

1-PLACE OF DEATH Maryland General Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Mr Earl Lorny

(a) RESIDENCE NO. 1639 N. Washington ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 7 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas Lorny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary A Fise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Earle Lorny

(Address) 1639 N. Washington

15 MAR 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1924

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to March 18, 1924, that I last saw him alive on March 17, 1924, and that death occurred, on the date stated above, at 3.32 P m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforated Duodenal Ulcer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of March 17 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical-Lab. Dgs.

(Signed) Jno A Thompson M. D.

, 19 (Address) M G Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 20 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

D 84990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 84990

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2145 Walbrook Ave ST., 15 WARD)

2-FULL NAME John A Sohn

(a) RESIDENCE NO. 2145 Walbrook Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Sohn

6 DATE OF BIRTH (month, day, and year) Dec 5, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stonecutter

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Sohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dora Sohn

(Address) 4125 Walbrook Ave

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

MAR 19 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 25, 1924, to Mar. 17th 1924, that I last saw h.. alive on Mar. 17th, 1924, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Ambulatory Erysipelas

(duration) ..... yrs. ..... mos 2 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? All symptoms

(Signed) O. H. Hoffman, M. D.

3-17-1924 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Mar 20 1924

20 UNDERTAKER Wm. Cook

ADDRESS 502 E Northern

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84991

CERTIFICATE OF DEATH.

D 84991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Hoffman ST., 11 WARD)

REGISTERED NO. 74-

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Young

(a) RESIDENCE No. 413 N. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Dennis Young

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49				

8 OCCUPATION OF DECEASED House Wife 037

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Husband Dennis Young (Address) 413-N Hoffman St

15 Filed MAR 19 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 19 24

17

I HEREBY CERTIFY, That I attended deceased from March 8, 19 24 to March 17, 19 24, that I last saw h alive on March 17, 19 24, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edw. J. Kuntz, M. D.

3/17, 1924 (Address) 1230 S. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	March 19, 1924
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	1726 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84992

CERTIFICATE OF DEATH.

11-001

D 84992

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3010 Clifton Av St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugenia Lloyd Wilson

(a) Residence No. 3010 Clifton St., Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? 66 yrs. 9 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. R. Wilson

6-DATE OF BIRTH (month, day and year) May 19 1857

7-AGE. 66 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town)..... Baltimore (State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER. Henry Lloyd

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Eugenia M. McDonald

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Mr. Henry Wilson (Son)

(Address) 3025 Clifton Ave

MAR 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17 1924.

17- I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 17, 1924, that I last saw h.. alive on Jan 16, 1924 and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Influenza and Bronch Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Harold L. Gatch, M. D.

3/19/24 19 (Address) 3070 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery

DATE OF BURIAL, Mar 19 19 24

20-UNDERTAKER. J. E. MOWEN COMPANY (William F. Wooden, Successor)

ADDRESS 103 W. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho in plain terms, so that it may be properly classifie instructions on back of certificates. Exact statement of OCCUPA

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 84993

CERTIFICATE OF DEATH.

D 84993

127

1-PLACE ~~OF DEATH~~

CITY OF BALTIMORE: (No. 127 Prospect Av ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Estelle Hooper

(a) RESIDENCE NO. 127 Prospect Av ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? 59 yrs. 10 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. V. Hooper

6 DATE OF BIRTH (month, day, and year) Apr-21-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Matthew Gormley

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known

(State or country) not known

14 Informant Mr. Chas. H. Thompson (Son in law)

(Address) 127 Prospect Av

15 MAR 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 1924, to Mar 17 1924, that I last saw her alive on Mar 16 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hoen, M. D.

3-17, 1924 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy

DATE OF BURIAL Mar 19 1924

20 UNDERTAKER STUART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 84994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84994

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1836 Bolton St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Sophia Berry

(a) Residence No. 1836 Bolton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John A Berry

6-DATE OF BIRTH (month, day and year) Dec 2 1837

7-AGE 86 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Isaac Read

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Guilford County

12-MAIDEN NAME OF MOTHER, Frances Guilmore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Guilford County

14- (Informant) Mrs Frances M Berry

(Address) 1836 Bolton St

15- Filed MAR 19 1924 ROBERT R. KRAUTH, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19-1924

17- I HEREBY CERTIFY, That I attended deceased from February 1924, to March 19 1924, that I last saw her alive on March 18 1924, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach -

Carcinomatosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles J. Buchman M. D.

19 (Address) 1417 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Detroit Mich. | DATE OF BURIAL: March 1924

20-UNDERTAKER: W. F. Simmons Sons | ADDRESS: North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 84995

D 84995

1-PLACE OF DEATH

City of BALTIMORE: (No. 1618 Riggs Ave St. 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Griffin.

(a) Residence No. 1618 Riggs Ave. Balto St., Ward.....

(Usual place of abode)

(If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3/15/24

7-AGE. ....0.....yrs.. mos. 2 ds. If LESS than 1 day, .hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Leroy Waters

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Julia Griffin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Gloucester Va.

14- (Informant) Julia Griffin

(Address) 1618 Riggs Ave. Balto.

15- MAR 19 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

91

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/17/24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 15 1924 to Mar. 17, 1924.

that I last saw he alive on Mar. 16, 1924.

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration) yrs. mos. ds.

CONTRIBUTORY.....

(Secondary)

.....(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) C. Mansell Lawrence, M. D.

19 (Address) 1018 N. Stricker St. City.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** See reverse side for additional space.)

19-PLACE OF BURIAL CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19..
HOPKINS HOSPITAL	
20-UNDERTAKER. Commissioner of Health.	ADDRESS MAR 18 1924

Spec.—1-10-21—M&T—1500 Blks.

D 84996 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 46 D 84996

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 W. Hoffman ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jackson

(a) RESIDENCE No. 603 W. Hoffman ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 621

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Abbie Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Delcain Jackson

(Address) 603 W. Hoffman

15 Filed MAR 19 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar. 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 11 1924 to Mar. 15 1924

that I last saw her alive on Mar. 17 1924

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows

Pneumonia Lobar

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) W. J. Carr Jr., M. D.

, 19 (Address) 515 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3-19 1924

20 UNDERTAKER John H. Joadum — ADDRESS 1923 Ursiel St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEE 1 TY

K-S-A-F

Cor.—1-12-23—M&T—100 Bks.

D 84997

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 84997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1937 Penna Ave ST. 14 WARD)

2-FULL NAME Charles E. Taylor.

(a) RESIDENCE NO. 1937 Penna Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Taylor.

6 DATE OF BIRTH (month, day, and year) Jan 5 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Thos. Dixon Co.

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Gilbert Taylor

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Durrell

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. C. E. Taylor
(Address) 1937 Penna. Ave.

15 Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)
March 19, 1924 (Address) 282 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 19 1924
20 UNDERTAKER Sam'l H Grace & Son	ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 lbs.

D 84998

HEALTH DEPARTMENT—CITY OF BALTIMORE

84998

100-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Smith ST., 16 WARD)

2-FULL NAME Robert Stanford Carter

(a) RESIDENCE No. 1309 Smith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Rudolph Carter

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Mary Stanford

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Mary Stanford
(Address) 1309 Smith Av

15 Filed MAR 19 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1924, to Mar 18, 1924, that I last saw him alive on Mar 18, 1924, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

(Broncho Pneumonia
(Primary)

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emelliann Frey M. D.

3/18, 1924 (Address) 1927 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Mch 19, 1924

20 UNDERTAKER Sam'l W. Chase Hen

ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 84999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002 D 84999

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2205 Ettrig ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Rike

(a) RESIDENCE NO. 2205 Ettrig ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 12 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Rice

(Address) 2205 Ettrig St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MAR 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9 1924, to March 17 1924, that I last saw her alive on Mar 17 1924, and that death occurred, on the date stated above, at 7 A.M. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) W. J. Coleman M. D.

March 18, 1924 (Address) 503 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Va	March 19, 1924
20 UNDERTAKER	ADDRESS
Sam'l. W. Chase Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85000

D 85000

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No.) U.S. Marine Hospital No 1 ST., 18 WARD)

2-FULL NAME Herbert Lee Jackson.

(a) RESIDENCE NO. 914 W. Lexington St. ST., WARD

(Usual place of abode) Baltimore Md.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] Jackson

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work, Seaman Coast G. Cutter "Apache"

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.C.G. "Apache"

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lottie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Lottie Jackson 914 W. Lexington St.

15 MAR 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1924.

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1924. to March 17, 1924.

that I last saw him alive on March 17, 1924,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Oedema of lungs, following Ether anesthesia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation for ruptured appendix (duration) yrs. mos. 8 ds.

18 Where was disease contracted? (not at place of death) U.S. Marine Hospital

Did an operation precede death? Yes Date of 3/17/24

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) M. X. Foster, M. D.

Mar. 19 (Address) U.S. Marine Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington Cemetery	March 19 1924
20 UNDERTAKER Wm R A Elliott	ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85001

CERTIFICATE OF DEATH.

66 D 85001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 305 Groome Al. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Perry Evans (C).

(a) RESIDENCE No 305 Groome Al ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant John Henry. (C).
(Address) 305 Groome Al.

15 Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

86

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Rombardt, M. D. (Coroner.)

March 18, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL: MAR 19 1924 192

20 UNDERTAKER — ADDRESS

MAR 19 1924 THE MORGUE.

Commissioner of Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85002

33 D 85002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward).

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Taylor

(a) Residence No. 930 N. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1903

7-AGE. 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Lewis Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- MAR 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-18-24

17- I HEREBY CERTIFY, That I attended deceased from 3-11, 1924 to 3-18, 1924

that I last saw h[illegible] alive on 3-18, 1924

and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(Duration) yrs. 2 mns. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude J. Brace, M. D.

3-18, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Co Va — DATE OF BURIAL. 3/19/24

20-UNDERTAKER. Samuel J. Handley — ADDRESS. Middleburg Va

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85003

CERTIFICATE OF DEATH.

117 D 85003

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts., 22 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Jones

(a) RESIDENCE NO. 735 Hanover St Baltimore WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/9/1909

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md
(State or country)

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Louise Jones

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Univ. Hospital Records
(Address) Lombard & Greene Sts

15 Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1924

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1924, to March 19, 1924, that I last saw him alive on March 19, 1924, and that death occurred, on the date stated above, at 12 50 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.
Bronchopneumonia

Known Since (Duration) March 16—1924 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix (duration) not known ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of March 16—1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W. Wallace Walker M. D.

, 19 (Address) Lombard & Greene Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Somerset Co—Md. DATE OF BURIAL March 20 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85004 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85004

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Glenedward Ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Corlizzo

(a) RESIDENCE NO. 414 Glenedward Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29-1924

7 AGE — Years: — Months: 1 Days: 18 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. City

PARENTS

10 NAME OF FATHER: Pio Corlizzo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Concetta Corsi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant (Address) Annie Corlizzo 414 Glenedward Ave

15 Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 16th, 1924, to Mar 18th, 1924, that I last saw h alive on Mar 17th, 1924, and that death occurred, on the date stated above, at 1 PM m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. H. Corse, M. D.

, 19 (Address) 2409 Ind. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent — DATE OF BURIAL: May 20 1924

20 UNDERTAKER: H S Marshall — ADDRESS: 3539 Fall Road

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 85005 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

D 85005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 18 Ward)

Registered No. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Sprow

(a) Residence No. 871 Boyd st. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1909

7-AGE. 14 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, Samuel Sprow

11-BIRTHPLACE OF FATHER (city or town) (State or Country). West Indies

12-MAIDEN NAME OF MOTHER Georgianna Hutton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Hospital Records

(Address) M.T.H.

15- Filed MAR 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from November 14 19 23 to March 17 19 24

that I last saw him alive on March 17 19 24

and that death occurred, on the date stated above, at 10.40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) [illegible] M. D.

3-18-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel Cemetery	March 21 1924
20-UNDERTAKER,	ADDRESS
Jno Geo H Hooper	406 W. Conway St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.